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Protecting the Vulnerable in Times of Vulnerability Infant and Young Child Feeding in Emergencies – Lebanon

Shaker, Linda

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Protecting the Vulnerable in Times of Vulnerability

Infant and Young Child Feeding in Emergencies – Lebanon

Linda Shaker Berbari

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This thesis is dedicated to the memory of my beloved mother and father;

Nidal Bou Said and Maître Zakaria Shaker

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DECLARATION

I, Linda Shaker Berbari, declare that I am the author of this thesis, that all references cited have been consulted by myself; that the work of which the thesis is a record has been done by myself; that this work has not been previously accepted for a higher degree.

7th March 2018

Andrew SYMON, Supervisor

7th March 2018

Annie ANDERSON, Supervisor

ABSTRACT

Infant and young child feeding (IYCF) has a lifelong influence on health and is critically important during emergencies. Policies and guidance are designed to support IYCF in emergencies (IYCF-E), but are seldom fully implemented.

Lebanon has a long history of national emergencies and is currently hosting 1.2 million Syrian refugees. Lebanese infant feeding practices are sub-optimal overall. To respond adequately in emergencies, there is a need to understand how best to address the nutritional needs of vulnerable infants and young children.

This single-case study with three-level embedded units of analysis examines policies and programmes on IYCF-E in Lebanon. The study utilised a desk review comprising existing policies and guidance at all levels; a survey questionnaire targeting non-governmental organisations (n=54) (organisational level); semi-structured interviews with 12 stakeholders (central level), and focus groups with health care providers (n=8) and mothers (n=8) (service provision level). Descriptive analyses were used for survey data and thematic analysis for qualitative data.

Existing policies were based on international guidance. However, despite notable efforts, these have not been fully implemented, disseminated or enforced at all levels. Policies were not part of a national strategy and IYCF-E was not integrated within national emergency preparedness plans. Programmes at each level lacked the necessary services to support mothers, notably an absence of counselling and support and a reliance on support from international organisations. Barriers include the lack of awareness and prioritisation of recommended IYCF practices and policies, gaps in human and financial resources, operational challenges and the influence of the infant

formula industry which have combined to hinder the advancement of adequate IYCF policies and practices.

Opportunities include the need to establish, organise, prioritise, and implement IYCF plans that are integrated within health and emergency plans, and disseminated. Any initiative needs to be evaluated and documented through rigorous implementation research.

LIST OF ACRONYMS

BFHI	Baby-Friendly Hospital Initiative
BGM	Breastfeeding Gear Model
BMS	Breast Milk Substitutes
DG	Director General
ENN	Emergency Nutrition Network
EUA	Embedded Unit of Analysis
FAO	Food and Agriculture Organisation
FIs	Feeding Indicators
GSIYCF	Global Strategy on Infant and Young Child Feeding
HCP	Health Care Provider
IASC	Inter-Agency Standing Committee
IBFAN	International Baby Food Action Network
ICN	International Conference on Nutrition
INGO	International Non-Governmental Organisation
IPC	Integrated Food Security Phase Classification
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
LCRP	Lebanon Crisis Response Plan
LMICs	Low and Middle Income Countries
LNGO	Local Non-Governmental Organisation

MDGs	Millennium Development Goals
MICS	Multiple Indicators Cluster Survey
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
NetCode	Network for Global Monitoring and Support for Implementation of the Code
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NNP	National Network of PHCs
OG-IYCF-E	Operational Guidance on Infant and Young Child Feeding in Emergencies
PAPFAM	Pan Arab Project for Family Health
PROBIT	Promotion of Breastfeeding Intervention Trial
PHCCs	Primary Health Care Centres
RCTs	Randomised Controlled Trials
RoL	Republic of Lebanon
RRP	Regional Response Plan
SACN	Scientific Advisory Committee on Nutrition
SAM	Severe Acute Malnutrition
SDCs	Social Development Centres
SDGs	Sustainable Development Goals
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme

UNSD	United Nations Sustainable Development
UREC	University of Dundee Research Ethics Committee
VASyr	Vulnerability Assessment of Syrian Refugees
WABA	World Alliance for Breastfeeding Action
WBTi	World Breastfeeding Trend Initiative
WHA	World Health Assembly
WHO	World Health Organisation
WCRF	World Cancer Research Fund

Chapter 1 INTRODUCTION

This thesis is concerned with infant and young child feeding in emergencies (IYCF-E) in the context of Lebanon during the Syrian crisis. It explores the level of preparedness around emergencies and the extent to which provisions are established to ensure desirable infant and young child feeding (IYCF) practices are promoted, supported, and protected during emergencies.

Appropriate IYCF is essential for adequate growth, development, and survival. Facilitating adherence to recommended IYCF practices becomes vital during emergency situations (e.g. civil unrest, natural disasters) where access to health care, clean water, and adequate nutrition can be compromised (World Health Organisation [WHO] & United Nation's Children Fund [UNICEF], 2003). Despite the established value of supporting IYCF-E, and even though international guidelines exist, practices continue to be affected during emergency situations (Gribble, McGrath, MacLaine, & Lhotska, 2011). Lebanon, a small country in the Middle East with a native population of around four million, has experienced a number of emergencies and continues to do so with the current Syrian crisis, where it is host to around 1.2 million refugees from Syria (United Nations Higher Commission for Refugees [UNHCR], 2017). Reports from previous emergencies have highlighted gaps in IYCF-E support in Lebanon (MacLaine, 2006). However, no empirical research has been conducted to evaluate the level of preparedness in IYCF-E and the extent to which provisions are established to ensure the nutritional needs of vulnerable infants and children are met. A better understanding of the situation in relation to IYCF-E in Lebanon would help policy

makers and stakeholders improve policy development and implementation of initiatives during and before emergencies.

This research, focusing on IYCF-E, was initially inspired prior to the current Syrian crisis; as a result of the researcher's own observations and engagement in IYCF programming in Lebanon and attendance of a nutrition in emergencies regional training which highlighted the importance of emergency preparedness (Ghattas, Shaker-Berbari, & Obeid, 2014).

The study design (a single-case study with embedded multiple units of analysis) requires the thesis to be organised in a way that highlights the context where the Case is examined. In addition, having multiple units of analysis makes it important to present each unit in a separate chapter and a convergence of the results, or presentation of the Case, in a final chapter.

This thesis is divided into eight chapters.

Chapter 1 is an introduction to the thesis and its organisation.

Chapter 2 reviews the literature on the importance of IYCF with respect to health and other outcomes. It presents trends in feeding practices at the global level and recommendations for optimal IYCF. The chapter highlights the importance of IYCF in relation to health during emergency situations. It elaborates on the context where the research is implemented presenting a summary about Lebanon and the prevalent

feeding practices. It includes an overview on the refugee crisis including feeding practices amongst refugees hosted in the country. At the end of the chapter, a rationale for conducting this research is presented as well as the aims and objectives.

Chapter 3 presents the study methodology, methods, analysis, and ethical considerations.

Chapter 4 is an examination of existing global and national (Lebanon) IYCF-E policies and guidance. It is a document review and is part of the findings of this thesis.

Chapters 5, 6, and 7 each present the findings within one unit of analysis (central level, organisational, and service provision). Each chapter is an examination of the Case addressing the research objectives for a particular level; exploring IYCF-E policies and activities. Each of the chapters consists of a results section and a discussion reflecting on the literature including the document review.

Chapter 8 seeks to present the Case by converging results from all units of analysis and different methods of data collection. The chapter is a synthesis of results reflecting on the literature. It also includes a presentation of strengths and limitations of the study, the possible research implications, and a conclusion.

Chapter 2 BACKGROUND

This chapter provides a review of the literature on IYCF, its importance during normal and emergency situations, as well as gaps in feeding practices. Sections 2.1 and 2.2 include a review of the importance of IYCF in relation to health and other outcomes (short-term and long-term, maternal and infant), the recommendations for optimal IYCF, and an overview on current feeding practices and trends around the world. Section 2.3 includes an introduction to nutrition in emergencies and the importance of IYCF-E in relation to health and other outcomes as well as recommendations for appropriate IYCF during emergencies.

In addition to the background information on IYCF which helped shape the research, this chapter also includes an overview about the context; Lebanon. Sections 2.4 and 2.5 cover current feeding practices and trends in Lebanon, present an overview of the refugee situation and prevalent feeding and nutrition practices amongst affected populations in Lebanon.

Section 2.1 Infant and Young Child Feeding – Health Perspectives

The period between birth and two years of life provides a critical window of opportunity for ensuring optimal growth and development in children with effects on health outcomes in later life (Barker, 2004). Achieving and maintaining optimal eating habits during this stage are vital for ensuring appropriate short and long-term growth trajectories, good health, and to reduce the risk of disease (WHO & UNICEF, 2003). Breastfeeding has been described as the “unequalled way of providing ideal food for

the healthy growth and development of infants" (WHO & UNICEF, 2003, p. 7) and it has been said that "breast milk makes the world healthier, smarter, and more equal" ("Breastfeeding", 2016). Breast milk is the natural source of nutrition for infants until six months, beyond which, complementary feeding (in addition to breast milk) become necessary to meet the increased energy and nutrient needs of the growing infant and young child (WHO & UNICEF).

Recommendations for optimal IYCF are set out by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) in the Global Strategy for Infant and Young Child Feeding (WHO & UNICEF, 2003) as follows:

1- Exclusive breastfeeding for the first six months of an infant's life - i.e. for the first 180 days of an infant's life. Exclusive breastfeeding is defined as "an infant receiving only breast milk from his or her mother or a wet nurse, or expressed breast milk, and no other liquids or solids, not even water, with the exception of oral rehydration solution, drops or syrups such as vitamins, minerals supplements or medicines" (WHO, 2016i).
2- Introduction of nutritionally adequate and safe complementary feeding starting from the age of six months with continued breastfeeding up to two years of age or beyond. Complementary feeding is defined as "the process starting when breast milk is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk". Complementary feeding should be timely, adequate,

> safe, and properly introduced (Pan American Health Organisation [PAHO] & WHO, 2003, p. 8).

In addition, WHO recommends that breastfeeding be initiated during the first hour after birth (WHO, 2017e).

Recommendations are based on a systematic review conducted by Kramer and Kakuma which was updated in 2012 (Kramer & Kakuma, 2012). The review, that included two controlled trials and 21 observational studies, was conducted to study the effects of exclusive breastfeeding for six months as opposed to three to four months on child health, growth, development, and maternal health. It concluded that based on the available evidence, that there are "no apparent risks" in recommending exclusive breastfeeding for six months in both developing and developed countries (Kramer & Kakuma, p. 11).

Improving worldwide IYCF practices supports the Global Strategy on Infant and Young Child Feeding (GSIYCF) which aims to protect, promote, and support IYCF to optimise nutrition status, growth, development, health, and survival of infants and young children (WHO & UNICEF, 2003). Ensuring abidance by recommended IYCF practices is also in concordance with achieving the Sustainable Development Goals (SDGs) by 2030. The third SDG includes child health and interventions to protect, promote, and support optimal IYCF practices have been shown to contribute to preventing child deaths (Black et al., 2008; Victora et al., 2016). The third goal includes non-communicable diseases such as breast cancer and obesity also correlated to early feeding practices (Victora et al.). Optimal IYCF including breastfeeding are relevant to

the second SDG on nutrition, the first SDG on poverty and the eight SDG on economic growth and development (Victora et al.) as elaborated below.

This section is a review of the evidence on the benefits and influences of early feeding. Before presenting this summary, it is important to acknowledge some of the issues related to the evidence on IYCF, especially breastfeeding. It is well recognised that Randomised Controlled Trials (RCTs) provide the best evidence on the relation between an exposure and a health outcome (Horta, Victora, & WHO, 2013). However, RCTs are seldom conducted when it comes to infant feeding, especially breastfeeding, since it is considered unethical to randomly allocate infants to other than the recommended exclusive breastfeeding (Horta et al., 2013). Instead, randomisation occurs based on breastfeeding interventions. For example, the Promotion of Breastfeeding Intervention Trial (PROBIT) is a RCT where mothers are randomised according to a breastfeeding promotion initiative. Therefore, many of the evidence stems from cohort and observational studies (Scientific Advisory Committee on Nutrition [SACN], 2017, Victora et al., 2016) which are not used to deduce causation and may have a number of shortcomings. Retrospective studies for example are subject to recall bias and overestimating or underestimating breastfeeding duration may disrupt the investigated risk. This bias seems to increase with time passed since stopping breastfeeding. Huttly, Barros, Victora, Beria, and Vaughan (1990) reported that mothers who breastfed for a short period of time tend to overestimate breastfeeding while the opposite occurs with mothers who breastfed for a longer duration. These studies may also be subject to reverse causality which occurs when breastfeeding is stopped as a result of an infection or hospitalisation (Habicht,

DaVanzo, & Butz, 1986 in Horta et al., 2013). Observational studies also carry the risk of confounders which if not adjusted for might affect the impact (Horta et al.). In addition, the measurement of breastfeeding could present an issue given that the definition of "breastfeeding" may mean different behaviour in various studies and may be affected by a number of social confounders (SACN, 2017). For example, Victora et al. (2016) reported on reviews that varied in feeding classifications and presented evidence comparing shorter and longer durations of breastfeeding; as opposed to the standard breastfeeding indicators which were not used in many studies. On the other hand, experimental studies investigating human milk constituents and infant feeding do provide insight onto the mechanisms related to IYCF outcomes on health (Turin & Ochoa, 2014).

The following is a compilation of the latest evidence on IYCF and health outcomes based on reviews conducted between 2010 and 2015. Databases used for peer reviewed articles included: Medline, PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane Library, OvidSP (Maternal and Infant Care Database), SCOPUS, TRIP (Turning Research Into Practice), and Web of Knowledge. Search terms used included but were not limited to a single or a combination of the following terms: breastfeeding review, breastfeeding outcomes, breastfeeding benefit, early nutrition, early feeding, complementary feeding, breastfeeding in emergencies, infant feeding in emergencies, infant and young child feeding in emergencies, nutrition during emergencies, nutrition during crisis, breastfeeding trends. A scan for more recent evidence was conducted in 2016 and leading literature was included from 2017.

2.1.1 IYCF in relation to child mortality, morbidity, growth, development and longer-term effects.

Reducing infant and child mortality is one of the main SDGs and despite the progress in the improvement of child survival, the global rate did not meet the Millennium Development Goals (MDGs) target of a two-third reduction and remains 43 deaths per 1,000 live births in 2015 (United Nations Sustainable Development [UNSD], 2017). The Lancet series on Maternal and Child Nutrition (2013) reported that under-nutrition causes around 45% of child deaths resulting in 3.1 million deaths annually. Suboptimal breastfeeding alone was shown to result in more than 800,000 child deaths annually (Black et al., 2013). The series described interventions focusing on promotion of IYCF as one of the key interventions with the "largest potential effect" on mortality of children under five years of age (Bhutta et al., 2013, p 468). Later in the Lancet series on Breastfeeding in 2016, it was also estimated that 823,000 deaths would be saved if breastfeeding practices were extended in reach and duration (Victora et al., 2016). Victora et al. reported a strong protective effect of exclusive breastfeeding on the risk of mortality from infectious diseases. They examined reviews in both Low and Middle Income Countries (LMICs) and High Income Countries (HIC) although few studies were available from HIC. Also, few studies reported about mortality in relation to exclusive breastfeeding, the rest examined predominant breastfeeding or ever breastfed. The percentage reduction in mortality as a result of breastfeeding ranged from 12% to 50%. There is therefore a considerable body of evidence to show that breastfeeding contributes to child survival in both LMIC and HIC.

Liu et al. (2016) reported that around 45% of deaths in the under-fives occurred in the neonatal period. Breastfeeding has been shown to contribute to a decrease in neonatal mortality, especially the early initiation. Recently, Smith et al. (2017) conducted a systematic review on the impact of early initiation of breastfeeding on the risk of mortality. Although none of the reviewed studies were RCTs and most were cohort studies, the correlations showed that the earlier the initiation of breastfeeding the lower the rate of neonatal mortality.

Breastfeeding contributes to a decrease in mortality mainly due to the potential to contribute to decreasing the burden of disease, namely infectious diseases. Globally, 64% of under-five mortality is linked to infectious diseases particularly gastrointestinal and respiratory diseases (Liu et al., 2012) and reducing the burden of disease contributes to a decrease in mortality. There is a large body of evidence that shows that breastfeeding has a protective effect against infections (Abrahams & Labbok, 2011; Bhutta, et al., 2013; Bowatte et al., 2015; Carreira, Bastos, Peleteiro, & Lunet, 2015; Duijts, Jaddoe, Hofman, & Moll, 2010; Horta et al., 2013; Ip, Chung, Raman, Trikalinos, & Lau, 2009; Ladomenou, Moschandreas, Kafatos, Tselentis, & Galanakis, 2010; Sankar et al., 2015) and that this is most evident when babies are exclusively breast fed for six months (Kramer & Kakuma, 2012).

One of the most common childhood infectious diseases is respiratory tract infection which contributes to around 16% of the global under-five mortality rate (Liu et al., 2016). Ip (2007 & 2009) reported that the risk of hospitalisation from lower respiratory tract infections during the first year of a child's life decreases by 72% amongst infants

who are exclusively breastfed beyond four months. All the reviewed studies were observational and conducted in developed countries and thus might not be representative. Later, Horta et al., (2013) examined studies mostly from LMICs and evidence was presented in the Lancet series (Victora et al., 2016). The series concluded that there is strong evidence of a reduction in severe respiratory infections in breastfed children with a third of the episodes being avoided by breastfeeding. Hospitalisation was also reported to be decreased by 57%. It should be noted that most of the reviewed studies were observational and subject to individual bias (Horta et al.).

Otitis media is another common childhood infection that predisposes children to morbidity and hospital admission. Ip (2007) reported that the risk of otitis media decreased by 23% with any breastfeeding compared to exclusive formula feeding and serious ear and throat infections are reduced by 63% in infants with exclusive breastfeeding for six months. For the reviewed studies, it was unclear how breastfeeding data was collected and may be subject to individual bias. The recent Lancet series on Breastfeeding also reported that breastfeeding protects against otitis media in children younger than two years of age (Victora et al., 2016). The review however included studies that were mostly from HICs and for several studies, some confounders were not accounted for.

The mechanism of this contribution is suggested to be linked to the breast milk protective components including immunoglobulins, white blood cells, as well as bioactive components such as whey proteins and oligosaccharides which protect

against infections (Goldman, 2007; Lawrence & Lawrence, 2010). For example, IgA antibodies secreted in mothers' milk may transfer immunity to children (Tamura et al., 1991). Chirico, Marzollo, Cortinovis, Fonte, and Gasparoni (2008) investigated the role of breast milk in protecting against infectious diseases. They found that bioactive factors such as the immunoglobulins, lymphocytes, neutrophils, and cytokines present in breast milk play a role in boosting the immune response through their anti-inflammatory effect. In addition, oligosaccharides may hinder the attachment of pathogens to the infant's mucosa contributing to preventing respiratory infections (Hanson et al., 2002). Particularly in low income settings, improved nutritional status as a result of breastfeeding may contribute to a decreased risk of infection (Horta et al., 2013).

In addition to protection during the breastfeeding period, there is emerging evidence to show that the anti-infective benefits for breastfeeding may extend beyond the period of breastfeeding leading to long-lasting protective effects (Hanson et al., 2002; Ruowei et al., 2014; Tromp et al., 2017). These are still individual studies and further investigation is warranted as to the longer term risk of respiratory tract infections.

Diarrhoea and gastrointestinal tract infections continue to be one of the leading causes of death amongst children under five years, contributing to over 9% of child mortality (Liu et al., 2016). Breastfeeding has been reported to have protective effects against the incidence of diarrhoea. This effect was reviewed by Lamberti, Walker, Noiman, Victora, and Black (2011) who showed that the incidence of diarrhoea significantly increases with lack of breastfeeding. The relative risk for incidence of

diarrhoea ranged from 1.3 to 2.65 depending on the age and exclusivity of breastfeeding. The risk of mortality from diarrhoea was also increased reaching a relative risk of 10.5 in infants aged 0-5 months who are not breastfed. The review examined three categories of breastfeeding; exclusive, predominant and partial. Almost all reviewed studies were cohort studies with a high possibility of reverse causality as a consequence of hospitalisation or diarrhoea which may lead to overestimation of the protective effect of breastfeeding against the infection (Habicht et al., 1986 in Horta et al., 2013). The positive outcomes of breastfeeding are most apparent in developing countries, where risk of mortality from diarrhoea within infants less than six months is estimated to be ten times higher in non-breastfed infants as compared to breastfed infants (Black et al., 2008). Nevertheless, even in developed countries, the risk of infections is higher amongst non-breastfed infants (Fisk et al, 2011). Horta et al. (2013) reviewed the effect of breastfeeding on diarrhoea and included studies that were not in any previous systematic review. Forty-one (41) studies were identified providing 81 estimates on the relative risk of morbidity, mortality and hospitalisation from diarrhoea with infant feeding. The review acknowledged several biases including the presence of confounders and reverse causality. These were thoroughly discussed and accounted for. The review concluded that despite the biases, exclusive breastfeeding has a protective effect on incidence of diarrhoea with 80-90% decrease in mortality and hospital admission and 50% for morbidity. There is therefore sufficient strong evidence about the protective effect of breastfeeding against diarrhoea.

The mechanism of this protective effect has been investigated and several plausible scenarios proposed including the immunological properties, the avoidance of contaminants (when it comes to exclusive breastfeeding), and the nutritional status of the breastfed infant. As with other forms of infections, breast milk provides antibodies (secretory IgA) protecting the infant from infection (Palmeira & Carneiro-Sampaio, 2016). Also, Lactoferrin, one of the main proteins in breast milk, with its highest concentration in colostrum, has antimicrobial and anti-inflammatory properties as it binds to iron, essential for bacterial growth amongst other functions (Turin et al., 2014). Oligosacharides seem to also contribute to infection protection by reducing attachment of bacteria to the intestinal lining (Turin et al.). Breast milk may contribute to a decrease in diarrheal incidence by impacting gut integrity and the intestinal microflora. *Lactobacillus* and *Bifidobacteria* species, considered probiotics, colonise the intestine, contribute to decreasing infection by pathogens, and produce antimicrobial compounds (Fernandez et al., 2013).

Microbial colonisation has been shown to be affected by mode of delivery and diet. Breast milk contains more than 700 species of bacteria affecting the infant's intestinal flora (Cabrera-Rubio et al., 2012). Colonisation plays a range of roles including development of immune tolerance and production of vitamin K (Holgerson, Harnevik, Hernell, Tanner, & Johansson, 2011). In addition to affecting the intestinal flora, breast milk has been reported to influence the oral micro flora which may have implication for oral and long term health (Holgerson et al., 2013). Despite this contribution however, the evidence about breastfeeding and dental caries remains inconclusive. Breastfeeding has been shown to be associated with a reduction in malocclusions,

dental caries, however have also been reported to increase with nocturnal feeding. Still, reviewed studies do not control for the introduction of sugary food and are mostly in HICs (SACN, 2017).

The early introduction of complementary foods and drinks has also been linked to a greater risk of infections including respiratory and gastrointestinal despite inconsistent data. Kramer et al., (2001), through the PROBIT, reported that the early introduction of solids at four months was associated with greater risk of gastrointestinal, respiratory, and ear infections compared to exclusive breastfeeding until six months. Later, Kramer & Karkuma (2012) reviewed the evidence and found that exclusively breastfed infants for six months are less at risk of gastrointestinal infections. The timing of introduction of solid foods was also recently examined by SACN (2017) concluding that the introduction of solids before six months "presents risks that are not outweighed by any potential benefit". Therefore, there is a pool of evidence showing the importance of abiding by recommended feeding practices in support of child infectious diseases.

Common childhood illnesses include food allergies, atopic and autoimmune diseases. Although a number of individualised studies have investigated the association between early feeding regimens and risks for allergies, eczema and other atopic outcomes, the evidence is still inconclusive (Hector, Hebden, Innes-Hughes, & King, 2010; Robinson & Fall, 2012; Victora et al., 2016). Whilst some studies show no difference in the risk for such conditions between infants who are exclusively breastfed to six months and infants exclusively breastfed to three and four months

(Kramer & Kakuma 2004), others show some evidence when family history is taken into consideration (Ip et al., 2009; Nagel et al., 2009). The same applies to breastfeeding and eczema, where Matheson, Allen, and Tang (2012) reported equal numbers of studies showing positive or negative effect, although the majority showed no effect of breastfeeding on risk of developing eczema. Still, most reviewed studies had some form of methodological limitation. Victora et al. (2016) noted that although there was some statistically significant evidence in reduction in asthma with breastfeeding, however when tighter control of confounders was conducted the results were smaller and non-significant.

The effect of the timing and kind of complementary food on risk of development of allergies is an ongoing area of research. In their review, Hector et al. (2010) recommended the gradual introduction of complementary foods at six months along with continued breastfeeding to help prevent development of allergies. A recent consultation paper by SACN also recommended the introduction of potential allergens such as peanuts and eggs between six and twelve months. They concluded that the earlier introduction of such foods may present risks and the later introduction (beyond six to twelve months) may increase the risk of allergies to those foods (SACN, 2017).

As mentioned above, breast milk contains a number of factors that interact with the infant's intestinal milieu including cytokines and other components which may have a protective effect against allergies (Matheson et al., 2012). However, there is still a need for further investigation about the role of breastfeeding in relation to the development of allergies and atopic illnesses.

Child morbidity is linked to growth, development, and the overall nutritional status (UNICEF, 1990). Globally, there are 156 million children with stunted growth (UNICEF et al., 2016) defined as a child under five years of age, whose height for age is below minus two standard deviations from the median of the WHO Child Growth Standards. Stunting refers to stunted physical growth and a diminished mental and learning capacity during childhood with effects into adulthood (UNICEF et al.). Underweight affects children under-five and jeopardises their immunity and growth. 50 million children under five years of age suffer from wasting defined as a weight for height below minus two standard deviations from the median of the WHO Child Growth Standards (WHO, 2016e). Both stunting and wasting are affected by dietary intake (UNICEF, 1990). SACN (2011) highlighted the importance of adequate nutrition in the first two years of life when rapid growth occurs and nutrient restriction may produce irreversible changes in the body. The type of feeding in the early weeks of life has an impact on both the rate of growth and tissue composition (SACN, 2011). Ensuring that infants are exclusively breastfed until six months has been recommended by a number of reviews that examined the difference between introduction of solids at six months or before (Kramer & Kakuma, 2012; SACN, 2011; SACN, 2017). Although the rate of weight gain in early infancy is slower for breastfed infants (compared to artificially fed infants), it has been reported, with evidence from cohort studies, that breast milk provides adequate nourishment for the first six months of life and that it is not correlated with diminished stature in childhood and adulthood (Martin, Smith, Mangtani, Frankel, & Gunnell, 2002; Victora, Barros, Lima, Horta, & Wells, 2003).

Wells et al. (2012), through a RCT, confirmed that introducing complementary food before the recommended six months may compromise breast milk intake without achieving any growth advantage over infants who were introduced to complementary food at six months. The trial was not strict in the definition of exclusive breastfeeding and allowed for a maximum of 10 feedings of formula which may have altered the results. Marriott, White, Hadden, Davies, and Wallingford (2012) explored the association between Feeding Indicators (FIs), stunting, and underweight in 14 low income countries using data from the Demographic and Health Survey (DHS). Although data used was not from the same period for all examined countries, results showed that abiding by guidance for introducing complementary food at six to eight months was associated with lowered risk of stunting and underweight. Dietary diversity and the timely introduction of solid food were associated with a significantly lower risk of both stunting and underweight. When it came to other breastfeeding indicators, early initiation of breastfeeding was significantly associated with reduced risk for underweight. Extended breastfeeding however was correlated with a "higher probability" of underweight. This could not be explained although it is likely that the extended breastfeeding may have compromised consumption of foods rich in nutrients, notably iron containing foods. In fact, the evidence on breastfeeding per se has not been strong enough in relation to its effect on length and weight of children (Victora et al., 2016). The reviews confirm the importance of abiding by the recommended six months for the introduction of complementary food as the alternative will not benefit growth. There is still a need to further investigate the contribution of breastfeeding on the prevention of stunting and wasting.

Growth is linked to mental capacity and intelligence which is also related to a country's economic growth (Jones & Schneider, 2006). Breastfeeding has been shown to have positive impact on intelligence and cognitive functioning. A review of the literature shows that studies are consistent in terms of the effect of breastfeeding on intelligence although the issue of confounders has been raised on a number of occasions (Horta, Loret de Mola, & Victora, 2015b). A meta-analysis showed that cognitive function scores were higher amongst children who were breastfed compared with artificially fed children (Anderson, Johnstone, & Remley, 1999). A prolonged duration of breastfeeding was associated with greater intellectual capability during childhood and adulthood as shown by a prospective cohort study (Mortensen, Michaelsen, Sanders, & Reinisch, 2002). In an interventional RCT, the Intelligence Quotient (IQ) of children allocated to the breastfeeding promotion group was higher at 6.5 years of age by an average of 7.5 points (Kramer et al., 2008). Although this correlation has been debated in view of other confounders such as maternal intelligence, comparing both developed and developing countries showed that with adjustments for confounders, breastfeeding was still correlated with IQ (Brion et al., 2011). Horta et al. found that breastfeeding is related to improved performance in intelligence tests. A positive effect of breastfeeding on cognition was also observed suggesting the association was causal. The evidence was almost entirely based on a review of cohort studies. The review was referenced in the Lancet series on Breastfeeding which concluded that breastfeeding was associated with higher performance in intelligence tests in children and adolescents (Victora et al., 2016).

The association between breastfeeding and intelligence may be related to a number of factors. The presence of long-chain polyunsaturated fatty acids such as arachidonic acid and docosahexanoic acid in breast milk is thought to play a role in child development (Koletzko et al., 2001). Other constituents such as nucleotides, known to be conditionally essential nutrients for infants, have also been reported to have a role (Singhal et al., 2010). However little is known about the process (Robinson & Fall, 2012). Breastfeeding seems to also contribute to an increase in brain development, specifically the white matter (Isaacs et al., 2010). There is considerable evidence to show that breastfeeding influences performance and intelligence although the full mechanism behind this connection is yet to be fully explained.

Non-communicable diseases (NCDs) constitute major causes of mortality and morbidity in both children and adults. Over 42 million children globally are obese and this rate has increased by 11 million over the past 15 years (UNICEF et al., 2016). Obesity is correlated with a number of chronic diseases including hypertension, diabetes and some forms of cancers. Breastfeeding has been shown to protect against a number of risk factors of such chronic diseases (Horta, Loret de Mola, & Victora, 2015a; SACN, 2011). Breastfeeding has been reported to be protective against obesity. The SACN review (2011) showed that the relation between breastfeeding and decreased risk of obesity is consistent. Despite the potential bias in data related to weight and height, the review confirmed that breastfeeding, compared to artificial feeding, is associated with a decreased risk of obesity and this association is valid in both developed and developing countries. SACN reported that for up to nine-month duration of breastfeeding, each month is associated with a 4% decrease in risk of

obesity (SACN, 2011). Hector et al. (2010) also confirmed that breastfeeding to at least six months of age decreases the risk of overweight and obesity later in the life of that infant. Owen, Martin, Whincup, Smith, and Cook, (2005) and Weng, Redsell, Swift, Yang, and Glazebrook (2012) reviewed studies and showed that there is a 15% decrease in the risk for childhood overweight for infants who are breastfed. However, Ip et al. (2009) highlights that some confounders (such as education of mothers) may not have been taken into account in the analysis of the results. Victora et al. (2016) in the Lancet series on Breastfeeding reported based on Horta et al. (2015a) that longer periods of breastfeeding are associated with a 26% reduction in the odds of becoming overweight. Similar studies have confirmed this (Marseglia et al., 2015; Woo & Martin, 2015). Breastfeeding has also been shown to be protective against elevated blood pressure and elevated total blood cholesterol in later life (Hector et al., 2010; SACN, 2011) although recent reviews have not been able to confirm this association (Horta et al., 2016). Evidence from systematic reviews show breastfeeding is associated with a reduced risk of type II diabetes (Horta et al., 2015a; Ip et al., 2009; Taylor, Kacmar, Nothnagle, & Lawrence, 2005) and that breastfeeding may be one modifiable factor for its prevention (Pereira, Rita de Cássia, & Araújo, 2014).

The mechanism by which breastfeeding protects against such chronic diseases is not well understood. It is hypothesised that infants who are breastfed consume a lower total amount of energy and protein as compared to formula fed infants (Bartok & Ventura, 2009). The role of bioactive factors in breast milk is a growing area of research examining growth-regulating components such as Leptin involved in the regulation of adiposity (Savino et al., 2005). The impact of breastfeeding has been

linked to bioactive substances, which decrease insulin resistance (Pereira, et al., 2014) and breastfed infants have been shown to have a lower fasting insulin level (SACN, 2011). The evidence linking breastfeeding to obesity and type II diabetes is established however the mechanism of this contribution is not fully understood.

Leukaemia constitutes one of the most common forms of childhood cancers amounting to one out of three of cancer cases in children (Cancer Research UK, 2017); with around 175,000 cancer cases diagnosed annually amongst children under 15 years of age and an annual increase of 0.9% (Cancer.org, 2017). Breastfeeding may play a positive role in reducing the risk of acute lymphocytic leukaemia (ALL) (Rudant et al., 2010) and acute myelogenous leukaemia (AML) (Ip et al., 2009) in childhood. A meta-analysis conducted on studies from developed countries showed a decreased risk of leukaemia in children who were breastfed (SACN, 2011). Infants who were breastfed for six months or longer had a 20% decrease in the risk of ALL and 15% in the risk of AML (Rudant et al., 2010). Amitay & Keinan-Boker (2015) conducted a meta-analysis and included studies not featured in previous meta-analyses. They showed that 14%-19% of all childhood leukaemia cases may be prevented by breastfeeding for six months or more.

The mechanism for this protection is still unclear and is thought to be linked to the impact of human milk or to the reduction in risk of infections or inflammation (Rudant et al., 2010). It is hypothesised that the higher ratio of omega-6/omega-3 found in infant formula may promote more inflammation which in turn may be linked to obesity-related diseases such as cancers (Bartok & Ventura, 2009). It is also proposed

that the more favourable microbiome in a breastfed infant's gut and the stem cells in breast milk may explain the inverse relation between breastfeeding and leukaemia (Amitay & Keinan-Boker, 2015). The evidence linking breastfeeding to a lower incidence of childhood leukaemia is emerging with more research needed to further explain the mechanisms behind this relation.

2.1.2 IYCF and maternal health outcomes.

Breast cancer is globally the most frequent cancer in women with more than 1.5 million new cases diagnosed each year and an increase in incidence over time (WHO, 2017a). Breastfeeding has been reported to reduce the risk of breast cancer. The recent report by the Continuous Update Project (CUP) of the World Research Cancer Fund (WRCF) based on the Breast Cancer Systematic Literature Review (SLR) described the contribution of breastfeeding to breast cancer as "probable" for both pre and post-menopausal cancer (World Research Cancer Fund [WCRF]/American Institute for Cancer Research [AICR], 2017). That is, compared to the earlier report where the evidence was reported to be "convincing" (WCRF/AICR, 2014). Still, the report acknowledges that the CUP finding was stronger than that reported in the 2005 SLR and that although the evidence was consistent for unspecified breast cancer (i.e. post or pre-menopausal), it was not consistent for pre or post-menopausal separately (WCRF/AICR, 2017). The review identified evidence from a pooled analysis (Collaborative Group, 2002) and two meta-analyses (Islami et al., 2015; Zhou et al., 2015) and reported a significant inverse association (2%) per five-months duration of breastfeeding with breast cancer. The meta-analyses included all cohort studies and reported on "ever" vs. "never" breastfeeding (Islami et al.) and "highest" vs. "lowest"

breastfeeding duration (Zhou et al.) and the type of cancer was unspecified. Earlier, the European Code against cancer reviewing available evidence including Collaborative Group and work by Norat et al. (2008) concluded that breastfeeding reduces a mother's breast cancer risk and recommended that mothers breastfeed if they can (Scoccianti et al., 2015). The Lancet series on Breastfeeding reported the findings from the pooled analysis by Collaborative Group of data from 30 countries and around 50,000 women. They reported that each 12-month increase in lifetime breastfeeding was associated with a reduction of 4.3% suggesting that the longer women breastfeed, the larger is the protection. The series concluded that there is robust inverse association between breastfeeding and breast cancer (Victora et al., 2016). The reported results did not vary according to menopausal status. There is consistent evidence linking breastfeeding with a lower risk of breast cancer.

The mechanism by which breastfeeding reduces the risk of breast cancer is reported to be linked to the hormonal influence of breastfeeding on breast tissue. It is hypothesised that due to the short-term amenorrhea that results from breastfeeding, oestrogen levels, associated with risk of postmenopausal breast cancer, are decreased in the breast (Key, Appleby, Barnes, & Reeves, 2002). In addition, the shedding of breast tissue during lactation and the rejuvenation of epithelial cells is linked to a decrease susceptibility of cells damage (WCRF/AICR, 2017). The evidence correlating breastfeeding to breast cancer is consistent with evidence emerging on the mechanisms linking this correlation.

Other common cancers in women include ovarian and endometrial cancer. The evidence associating breastfeeding to these cancers is still modest (Scoccianti et al., 2015; Victora et al, 2016). There is suggestive evidence from meta-analyses showing that the relative risk of ovarian cancer is significantly decreased by 8% for each five-month increase breastfeeding duration (Luan et al., 2013). Chowdhury et al. (2015) also conducted a meta-analysis from 41 studies and reported an 18% reduction associated with longer duration of breastfeeding after adjusting for confounders.

Other non-communicable and metabolic diseases including type II diabetes and obesity are considered one of the top causes of mortality in developing countries. Observational studies show that breastfeeding may reduce type II diabetes risk in mothers. The only recent meta-analysis compiling evidence from six cohort studies showed an odds ratio of 0.68 (95% CI: 0.57-0.82) (Aune, Norat, Romundstad, & Vatten, 2014). The mechanism behind the contribution of breastfeeding to metabolic diseases is suggested to be linked to adiposity. Gunderson (2008) showed that prolonged breastfeeding is associated with decreased incidence of metabolic syndrome. Bobrow, Quigley, Green, Reeves, and Beral (2013), conducted an analysis of 740,000 British women as part of the Million Women Study with long-term follow up. Findings showed that with each child, and for each six months of breastfeeding, women had a significantly lower Body Mass Index (BMI) (1%) than women who did not. A meta-analysis also showed a positive association between breastfeeding and weight change (Neville, McKinley, Holmes, Spence, & Woodside, 2014).

Mental health is considered an integral part of maternal health. Poor mental health, specifically maternal depression, is considered a risk factor for poor growth in young children (Surkan, Kennedy, Hurley, & Black, 2011). Lack of or short–term breastfeeding may be linked with increased risk for post-partum depression (Ip et al., 2009 and Gallup, Pipitone, Carrone, & Leadholm, 2010). In a prospective study on Arab women, breastfeeding at two months was significantly correlated with lower risk of postpartum depression at four months (Hamdan & Tamim, 2012). Figueiredo, Dias, Brandão, Canário, and Nunes-Costa (2013), in a review of the literature concluded that breastfeeding may offer protection from post-partum depression although methodological limitations were noted. A qualitative review of 48 studies revealed clear associations between breastfeeding and reduced maternal depression (Dias & Figueiredo, 2015), however it was noted that it is more likely the depression was affecting breastfeeding rather than the opposite (Victora et al., 2016). For example, Dennis & McQueen, (2009) found that post-partum depression was associated with unsuccessful breastfeeding or delayed initiation. Chowdhury et al. (2015) also concluded that the evidence is not clear in relation to breastfeeding and depression.

Evidence on the mechanism for the association between breastfeeding and mental health is emerging to clarify the processes involved. It has been reported that the hormonal processes that accompany breastfeeding and skin-to-skin contact, specifically the drop in cortisol, may play a role in attenuating stress response (Figueiredo et al., 2013). At the same time, the regulation of sleep patterns that accompany breastfeeding (Doan, Gardiner, Gay, & Lee, 2007) may play a role in decreasing the risk of post-partum depression. The association between breastfeeding

and depression is still not clear although there is emerging evidence on the physiological mechanism for this potential contribution.

2.1.3 IYCF and other societal outcomes.

Despite the global economic growth witnessed for the past years, there is still a need to accelerate efforts to meet the SDGs. Breastfeeding has been labelled as a "smart investment in people and in economies" (Hansen, 2016). The potential contribution of breastfeeding to decreased child mortality and morbidity as well as the impacts on cognitive capacity and maternal health, may lead to an economic impact. For example, a decrease in morbidity, linked to a decrease in hospitalisation is related to a lower cost of health care. The opposite also applies (Rollins et al., 2016). Low breastfeeding, linked with higher morbidity and cognition is associated with higher economic burden. In the US, low breastfeeding was associated with high economic costs and absenteeism (student and workforce) (Bartick & Reinhold, 2010). Bartick & Reinhold showed that if 90% of mothers in the US breastfed exclusively for six months, US$13 billion would be saved yearly. In the UK, it was shown that a moderate increase in breastfeeding rates would lead to an annual saving of about £40 million (Renfrew et al., 2012). The Lancet series on Breastfeeding conducted an analysis of the economic cost of morbidity and lower cognition (resulting from lower breastfeeding) and concluded that economic savings of US$300 billion each year could be averted through universal breastfeeding (Rollins et al.). In addition to the economic impact, breastfeeding has been suggested to contribute to ensuring health equality. Victora et al. (2016) noted how breastfeeding contributes to bridging the health gap between the rich and poor given that the highest breastfeeding rates were seen in lower

income countries as mentioned in Section 2.2 below. They suggest that the health gap would have been much larger in the absence of breastfeeding. Roberts, Carnahan, and Gakidou (2013) argue that promotion of breastfeeding across different socio-economic statuses has the potential to improve child health outcomes associated to health related inequities. Breastfeeding therefore contributes to both economic and social development.

Climate change and planetary warming are considered major global issues with atmospheric carbon dioxide levels reaching a highest peak in 2016 and a need to scale up environmental interventions (UNSD, 2017). Breastfeeding has been reported to have environmental outcomes. Breast milk is environmentally friendly and does not require any packaging (Francis & Mulford, 2002). It is not industrially manufactured nor processed; it "keeps the environment unharmed" (Linnecar, Gupta, Dadhich, & Bidla, 2014). At the same time, artificial breast milk substitutes (BMS) "leave an ecological footprint" and therefore are a source of nuisance to the environment (Rollins et al., 2016). An increase in breastfeeding practices is suggested to contribute to protecting the environment.

Section 2.2 Infant and Young Child Feeding Global Trends and Issues

Worldwide, breastfeeding and complementary feeding practices are documented at the national level and compiled by international agencies such as WHO, UNICEF and the World's Alliance for Breastfeeding Action (WABA).

In 2007, the Working Group on Infant and Young Child Feeding updated and developed a set of indicators for assessing IYCF (WHO, 2008). These Feeding Indicators (FIs) are used to assess IYCF practices at the national level and include (in addition to exclusive breastfeeding and complementary feeding), indicators related to early initiation of breastfeeding, dietary diversity and continued breastfeeding.

The main feeding indicators reported on are:

1) Early initiation of breastfeeding (less than one hour)
2) Exclusive breastfeeding (0-5 months)
3) Introduction of solid, semi-solid or soft foods (6-8 months)
4) Minimum meal frequency (6-23 months)
5) Minimum diet diversity (6-23 months)
6) Minimum acceptable diet (6-23 months)
7) Continued breastfeeding at one year (12-15 months)
8) Continued breastfeeding at two years (20-23 months)

One of the main data sources that includes information on breastfeeding and complementary feeding is the WHO Data Bank on Infant and Young Child Feeding. Created in 1991, the data bank was known as the Global Data Bank on Breastfeeding and aimed at monitoring the trends of breastfeeding. Since then, the Data Bank went through a number of modifications to include targets of the GSIYCF and is now called Data Bank on IYCF. The Data Bank includes data from national and regional surveys and is updated regularly (WHO, 2016d)

Another reference that reports on feeding practices of infants and young children is the annual UNICEF State of the World's Children Reports (UNICEF, 2016). The report includes most recent rates and indicators of breastfeeding and complementary feeding in addition to other child and maternal health indicators.

In 2004, the International Baby Food Action Network (IBFAN), one of the WABA's core partners, launched the World Breastfeeding Trends Initiative (WBTi), to track, assess and monitor the implementation of the GSIYCF (World Breastfeeding Trends Initiative [WBTI], 2016). The WBTi, in addition to tracking policy indicators, monitors IYCF indicators which are rated into different colour codes (worst to best) red, yellow, blue, and green.

Although a number of resources exist for reporting on feeding practices however, given the different approaches and the extent to which information is up-to-date means that such data should be used with caution. Victora et al. (2016) highlighted this issue while presenting global trends in breastfeeding and indicated that reporting on breastfeeding indicators is a challenge. There are a number of countries that do not report on the indicators – mostly high income countries in addition to the Middle East and Central Asia that are reported to have gaps in reporting (Roberts et al., 2013). When it exists, data differs from one country to another in terms of the source or method of obtaining data. Hector (2011) elaborated on a number of factors that play in with reporting on breastfeeding indicators. There are first limitations in the different methods of reporting on feeding practices be it reporting on the current status (24-hour recall) or the longer term-recall. For exclusive breastfeeding and the

reporting on the current status, a main criticism is that asking the mother about the last 24-hours is not indicative of the actual status of breastfeeding and may lead to misclassification. Also, in many cultures, it is custom for babies to receive liquids such as teas and tisane and this will lead to either an underestimation or overestimation of exclusive breastfeeding depending on the timing of the recall (Greiner, 2014). For longer-term recall, there is the challenge of recall bias and either over-estimating the duration or under-estimating (Hector, 2011). Despite challenges, the following is a compilation of the trends in breastfeeding and complementary feeding based on available data sources as well as main review studies.

2.2.1 Breastfeeding.

Internationally, global targets have been established against which trends and rates are compared and through which achievement is measured and corrective actions are triggered. The Global Nutrition Targets for 2025 endorsed by the World Health Assembly (WHA) include breastfeeding targets which consist of increasing the rates of exclusive breastfeeding in the first six months to at least 50% (WHO & UNICEF, 2014a).

In 2016, UNICEF's State of the World's Children Report reported that 43% of children are breastfed exclusively in the first six months (UNICEF, 2016b). Also, the rate of early initiation of breastfeeding within the recommended first hour after birth is 45% and 46% of children are still being breastfed at the ages of 20 to 23 months. However, these rates differ between different continents and countries. The lowest rates of exclusive breastfeeding for six months are seen in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) (27%), West and Central Africa

(29%), and East Asia and Pacific (31%) (UNICEF, 2016b). Similarly, for continued breastfeeding beyond six months and at age two years, rates range from an average of 24% in East Asia and Pacific and an average of 75% in South Asia (UNICEF, 2016b). For many of the European and HICs, breastfeeding indicators were not reported within the UNICEF report. Bosi, Eriksen, Sobko, Wijnhoven, and Breda (2016) published an overview of national data from the WHO European Region Member States on breastfeeding. The rate of exclusive breastfeeding at six months was reported to be between 1% and 49% with the lowest rate being in the UK. These reports highlighted how the highest rates of breastfeeding were seen in lower income countries.

Gupta et al. (2012) published results of the WBTi in the 40 countries that had completed their assessments and found that IYCF practices are suboptimal in the assessed countries. Within the countries studied, early initiation of breastfeeding was 51.3%, exclusive breastfeeding until six months was 42.5%, median duration of breastfeeding was 18.6 months, and rate of bottle feeding[1] was 32.1% (Gupta et al.).

2.2.2 Complementary feeding.

The State of the World's Children Report includes data on complementary feeding and the percentage of children who are introduced to solid and semi-solid food between six and eight months. Worldwide, in 2016, complementary feeding is initiated in 64% of children between six and eight months (UNICEF, 2016b). Results of the WBTI in 40

[1] Bottle feeding: any liquid (including breast milk) or any food or semi-solid food taken from a bottle liquid including non-human with nipple/teat milk and formula (WHO, 2016i)

countries also found that introduction of complementary feeding between six and eight months is 65.2% (Gupta et al., 2012).

The WHO report on feeding indicators in 2009 included indicators from different countries. Results on dietary diversity [2] were described as "alarming" with the percentage of children with minimum dietary diversity in 39 countries ranging from 4% to 84% and a global percentage of 22%. Minimum meal frequency[3] was also reported with a global percentage of 46% and children with minimum acceptable diet[4] as 11% (WHO, 2009). The UNICEF State of the World's Children Report reported a rate of 29% of children meeting the minimum diet diversity and only 16% having a minimum acceptable diet (UNICEF, 2016b).

2.2.3 Breastfeeding trends.

Breastfeeding figures have been changing over the years since the launch of the GSIYCF. According to the UNICEF global database, progress in IYCF practices has been modest with exclusive breastfeeding increasing from 36% to 43% (UNICEF DATA, 2017). Recently, Victora et al. (2016) reported that for LMICs, exclusive breastfeeding has increased by around 0.5 percentage points per year from 1993 to 2013. However, this rate is not enough to reach the target 50% set by WHA. A study conducted by Cai, Wardlaw, and Brown (2012) reviewed trends in breastfeeding in developing countries

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[2] Dietary Diversity = Measured as the proportion of children 6–23 months of age who receive foods from four or more food groups (WHO, UNICEF, & USAID, 2008).

[3] Minimum Meal frequency = proportion of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more (WHO, UNICEF, & USAID, 2008).

[4] Children with minimum acceptable diet = proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk) (WHO, UNICEF, & USAID, 2008).

based on the UNICEF global database. The study reported that prevalence of exclusive breastfeeding among infants in developing countries increased from 33% in 1995 to 39% in 2010 with a large improvement in West and Central Africa (Cai et al., 2012). Rapid and substantial increases in exclusive breastfeeding rates, often exceeding the proposed global target, have been achieved in individual countries in all regions, such as Cambodia (from 12% to 60% between 2000 and 2005), Mali (from 8% to 38% between 1996 and 2006) and Peru (from 33% to 64% between 1992 and 2007). South Asia has made the highest progress in exclusive breastfeeding increasing from 47% to 64% between around the year 2000 and around the year 2015 (UNICEF DATA). Rates have slightly increased from 21% to 30% amongst the CEE/CIS countries (UNICEF DATA). Data on trends for the remaining Infant Feeding Indicators (dietary diversity, meal frequency and quality) are scarce and are only pertinent to few countries.

Section 2.3 Infant and Young Child Feeding and Nutrition in Emergencies

2.3.1 Emergencies and nutritional emergencies.

The International Federation of the Red Cross and Red Crescent Societies (IFRC) defines an emergency or a disaster as a "sudden, calamitous event that seriously disrupts the functioning of a community or a society and causes human, material and economic or environmental losses that exceed the community's or society's ability to cope using its own resources" (International Federation of the Red Cross and Red Crescent [IFRC], 2013). A "Complex emergency" has been used to refer to a major humanitarian crisis that has multiple causes and that requires a system-wide response (Klugman, 1999; WHO, 2016b). According to the WHO, emergencies differ in terms of length (short-term or chronic), cause (natural, conflict-related, economic-political, or

complex), magnitude (number of people in crisis), impact (destruction of infrastructure, agricultural, health, or social systems), affected groups (internally displaced persons, refugees, or stable populations) and humanitarian response (large-scale response or no response) (WHO, 2015).

An emergency can impact the nutritional status of a population and lead to morbidity and mortality by affecting households and individuals (Young, 2004). During an emergency or crisis situation, a number of disruptions might occur including large-scale destruction of infrastructure, the collapse of essential services such as health care services, lack of water supply and sanitation, migration, and disruption of social systems. Crises can result in loss of family members, trauma, violence and a number of negative influences which can undermine household care and nutrition (Global Nutrition Cluster [GNC], 2017). Access to food, water, and other essential needs may be jeopardised. These factors, leading to migration and settlement in overcrowded shelters, and food insecurity, increase the impact at the individual level including increased risk of malnutrition, illness, and greater probability of mortality (Angood, 2014; Greaney, Pfiffner, & David Wilson, 2011).

Emergencies and crises have greater impact on the most vulnerable. Children under-five are considered vulnerable with rates of mortality doubling during emergencies (Moss, et al., 2006). In Kenya and during the crisis in 2011, the rates of child mortality amongst Somali refugee children increased to 52%. The rate of mortality in children under-five was 1.8 per 10,000 person-days. More than two-thirds of all deaths were linked to diarrhoea (25%), cough or other breathing difficulties (24%), or fever (19%)

(Polonsky, Ronsse, Ciglenecki, Rull, & Porten, 2013). Similarly, in the south-western Central African Republic and during the crisis in 2010, the rates of mortality amongst children under-five doubled (Caleo et al., 2012).

The causes of mortality amongst children include malnutrition and infectious diseases (Moss et al., 2006; Toole & Waldman, 1988; Roberts et al., 2001; Yip & Sharp, 1993). Malnutrition is defined as a state of deficiency, excess or imbalance in a person's energy and/or nutrient status (WHO, 2017d). The term malnutrition encompasses two groups of conditions; under-nutrition and over-nutrition. Under-nutrition includes wasting, underweight, stunting, and micronutrient deficiencies. Over-nutrition includes overweight, obesity, and other diet related NCDs such as heart diseases and diabetes. In some instances, both under and over-nutrition co-exist; for example, obesity with micronutrient deficiencies, which is referred to as the double burden of malnutrition (WHO, 2016c; WHO, 2016g).

The most common form of malnutrition during emergencies is under-nutrition which includes acute malnutrition (resulting in wasting and sometimes oedema), chronic malnutrition (resulting in stunting), and micronutrient malnutrition (resulting in a deficiency in one or more of the micronutrients) (WHO, 2016h). Still, the double burden of malnutrition may exist during emergencies (WHO, 2016g). The rate of malnutrition during crisis increases. 13.4% of children had acute malnutrition in the Kenyan crisis amongst Somali refugee children under-five years of age (Polonsky et al., 2013). Similarly, the rates of acute malnutrition in internally displaced Chadians during the 2006 crisis increased to 20% (Guerrier et al., 2009). Moderate and severe acute

malnutrition are of greatest concern because of the strong association with death. Children suffering from severe acute malnutrition (SAM) are nine times more likely to die than a healthy child (Black et al., 2008). In longer-term emergencies, acute malnutrition may be low but other forms of malnutrition are apparent including stunting. Micronutrient deficiencies are common during emergency-affected populations where poor diets and lack of dietary diversity lead to micronutrient deficiencies (WHO, 2016h). Deficiencies can also be exacerbated if they already exist. The most common micronutrient deficiencies in emergencies include those related to the consumption of fresh fruits and vegetables as well as animal products including vitamin A, iron, vitamin C, niacin, and thiamine, which may not be commonly seen in non-emergency settings (Prinzo & De Benoit, 2002).

Not all emergencies lead to nutritional emergencies or crisis in food and nutrition. Nutritional emergencies have been measured in terms of different indicators including levels of acute malnutrition (wasting and oedema) and chronic malnutrition (stunting) amongst children under-five, food insecurity, and mortality. Although there is no universally accepted definition of a 'nutritional emergency', different classifications have been suggested by various United Nations (UN) agencies in an attempt to classify the severity of food and nutritional emergencies. According to the Emergency Nutrition Network (ENN) a "nutrition crisis" or "nutrition emergency" refers to "a situation characterised by high mortality, high levels of acute malnutrition or absolute numbers of acutely malnourished individuals, that may or may not exist in conjunction with conflict" (Emergency Nutrition Network [ENN] & NutritionWorks, 2014). According to the Integrated Food Security Classification (IPC) Global Partners (2008),

a nutritional emergency is when the Crude Mortality Rate (CMR) is twice the baseline, the under-five mortality rate increases to more than 2-10/10,000/day, and when wasting (defined as weight for height z-score less than minus three standard deviations) is more than 15%. Recently, an “IPC for Acute malnutrition” was launched where in addition to wasting and CMR indicators, a set of protocols were put to classify areas based on acute malnutrition and other contributing factors including water, sanitation and health (IPC Global Partners, 2016).

In order to prevent nutrition emergencies and mitigate high rates of malnutrition, it is essential that the leading causes of under-nutrition and nutrition emergencies be presented. The UNICEF conceptual framework is a tool that depicts the different levels of causes of malnutrition including immediate, underlying, and basic causes (Figure 2-1). The framework was developed in 1990 and since then it has been refined and applied in emergency contexts.

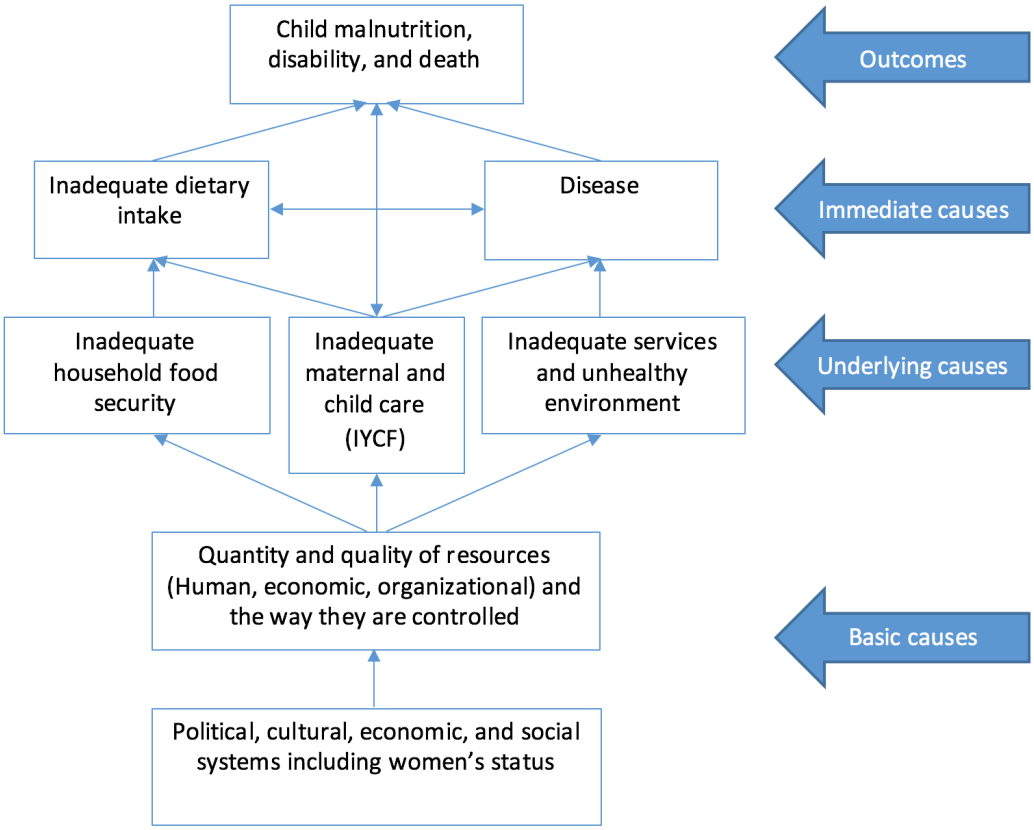


Figure 2-1 The UNICEF conceptual framework for under-nutrition (UNICEF, 1990)

According to the framework, the immediate causes of under-nutrition are lack of dietary intake and/or disease. These can be caused by "underlying" factors at the household or community level including inadequate household food security, inadequate care (child and maternal care), and inadequate services and unhealthy environment. The "basic" factors refer to resources available (human, structural, and financial) and the way they are used (political, legal, and cultural factors).

The framework also shows that under-nutrition and illness are interrelated and interact in a vicious cycle. When a child is undernourished, immunity to infection is

affected and therefore the child may fall ill. As the child falls ill, under-nutrition becomes worse (due to poor intake) leading to further deterioration of health and thus the vicious cycle which may become fatal. IYCF is part of the maternal and child care which is linked to inadequate intake, disease, and malnutrition (Scherbaum & Srour, 2016). An emergency further disrupts systems especially public health structures (Murray, King, Lopez, Tomijima, & Krug, 2002) and affects the different levels of causes of illness and under-nutrition thus making a population affected by an emergency more vulnerable.

2.3.2 Infant and young child feeding in emergencies.

While adhering to recommended IYCF practices is important for all infants, it becomes essential in situations of emergency where access to health care, clean water and adequate nutrition is limited (Carothers & Gribble, 2014). During emergencies, proper IYCF practices are crucial for normal growth, development as well as survival with the greatest consequences of inadequate habits seen in the poorest countries. Lack of breastfeeding as well as poor complementary feeding practices during emergencies can have negative effects on infants' and children's lives and ensuring adequate nutrition is key to reducing infant and child mortality and morbidity (WHO, 2016h). The following is a summary of different studies conducted that highlight the importance of adhering to recommended IYCF practices during emergencies including refugee situations. In addition to challenges related to collecting feeding indicators already highlighted earlier, it should be acknowledged that research during emergency and vulnerable situations presents further challenges given the unstable environment it is conducted in. Although improving, research during emergencies may

often present methodological challenges (Blanchet, Sistenich, Ramesh, Warren, & Hossain, 2015). Most reviewed studies used surveillance data and in emergency situations such existing systems may not be regularly functioning and thus may not be representative.

Breastfeeding plays a protective role and provides immunity against health hazards that infants may be exposed to during emergencies. According to a study conducted by WHO, not being breastfed in less developed countries increases the risk of mortality by six times in infants less than two months of age and by 40% in infants nine to 11 months (Victora & Barros, 2000). Breastfeeding was shown to contribute to a decrease in mortality in low resource settings. Edmond et al., (2006), with data from a surveillance system, showed that early initiation of breastfeeding contributed to a decreased risk of neonatal death by more than 22% in low-resource setting Ghana. Similarly, Mullany et al. (2008), with data from a RCT examining the effect of new born skin and umbilical cord cleansing, showed that initiation of breastfeeding within the first hour could prevent around 19% of neo-natal deaths in Southern Nepal. The study included data on more than 22,000 new born. It controlled for different confounders, however no data on maternal nutritional status was controlled for. Early on, Jakobsen et al. (2003), with data from a surveillance system in Guinea-Bissau during the war in 1998, compared mortality amongst children aged 9-20 months based on breastfeeding status. Non-breastfed children were six times more at risk of mortality compared with breastfed children. The study collected the same data two years prior to the war and found that this risk was absent emphasising the greater value of breastfeeding during emergencies. Published results of the impact of the war in Bosnia

(1992-1995) highlighted that non-breastfed infants under four months of age were more likely to become malnourished than their breastfed counterparts (Andersson, Paredes-Solís, Legorreta-Soberanis, Cockcroft, & Sherr, 2010). The study consisted of four linked cross-sectional surveys collecting data on breastfeeding and other factors related to child health. In another report, in Botswana, during a severe outbreak of diarrhoea in children due to heavy rain and contaminated water in 2006, non-breastfed infants were 50 times more likely to require hospitalisation and more likely to die than breastfed infants. Information was retrieved from Ministry of Health surveillance data (Creek et al., 2007). Following the 2009 earthquake in Jakarta, Hipgrave et al.'s (2012) survey, which examined the effects of donated infant formula, reported that one-week diarrhoea incidence was twice as much amongst infants who received donated infant formula than among those who did not. Although exclusive breastfeeding is important, there is evidence to show that any breastfeeding is also highly protective. Black et al. (2008) showed that the risk of mortality from any cause (pneumonia or diarrhoea) was 14 times more in non-breastfed infants than exclusively breastfed infants. At the same time, the risk of mortality in children who were either predominantly breastfed or partially breastfed was only 1.5 and 2.9 times (respectively) indicating the role of any breastfeeding as beneficial. When available, research on the importance of breastfeeding during emergencies demonstrate value in decreasing morbidity and mortality.

Artificial feeding during emergencies can jeopardise infant health. It carries a risk in normal situations which is amplified during emergencies largely due to poor hygienic conditions as well as lack of availability of safe BMS. Artificial feeding can increase the

risk of infection through the use of contaminated water or feeding devices in addition to intrinsic contamination (Gribble, 2011). Al-Sharbatti & AlJumaa (2012) reported through a case-control study that, in Iraq during the war, formula fed infants were found to have 2.7 times higher risk for Acute Respiratory Infections (ARI) compared to breastfed infants. The study compared a small sample of around 135 infants who were hospitalised for ARI with another randomly selected healthy sample. Following a tsunami affecting the villages of Pondicherry, an Indian Union Territory, Adhisivam, Srinivasan, Soudarssanane, Deepak Amalnath, and Nirmal Kumar (2006), conducted face-to-face interviews with mothers, and found that children who were reported to be artificially fed had three times the incidence of diarrhoea compared to those who were not. Even in high income countries, the risk of artificial feeding becomes higher in emergencies with the collapse of infrastructures and lack of water or access to feeding utensils and tools (Carothers & Gribble, 2014).

During emergencies, donations and the blanket (i.e. untargeted) distribution of BMS including infant formula and other forms of milk contributes to undermining breastfeeding (Hipgrave et al., 2012). First, the size of the donations is often beyond the identified need. During the Balkan crisis in 1990s, it was estimated that around 1.4 metric tons of baby food were donated in the first weeks of the emergency (Borrel et al., 2001). Second, emergencies can be used by the infant formula industry to market their products (Gribble, 2013). For example, in a community where an industry is not known, the free distribution of a certain brand of infant formula would contribute to the promotion of the industry producing that brand. Third, the distribution of infant formula without consideration to whether the infant is breastfed or not contributes

to an increase in artificial feeding (Adhisivam et al., 2006; Hipgrave et al., 2012). Hipgrave et al. showed that after the 2006 earthquake in Indonesia, 75% to 80% of households with babies received donations of infant formula and the consumption of all types of BMS was significantly higher amongst households that received donations compared to those that did not. Therefore, the untargeted distribution of BMS endangers feeding practices and may jeopardise otherwise healthy practices.

During emergencies, complementary feeding may be affected. As discussed in Section 2.1, complementary feeding is a critical part of a child's nutrition. In emergencies, complementary food may not be available, may not be safe, or may be inadequate. Very few empirical research has been published on the effects of inappropriate complementary feeding during emergencies. The IFE Core Group & Collaborators (2009) highlight that adequate, appropriate, safe, and timely complementary food during emergencies is equally important as breastfeeding. Especially when breastfeeding is lacking, inadequate complementary feeding increases the risk of malnutrition (IFE Core Group & Collaborators).

Emergencies may lead to shortage and poor access to food and breastfeeding contributes to ensuring access to nutrition in times of food insecurity. Food security encompasses availability, accessibility, utilisation, and stability of nutritionally appropriate and acceptable quantities of nutrition (FAO, 2006); the absence of which is linked to malnutrition (UNICEF, 1990). Breastfeeding has been shown to contribute to food security. Salmon, (2015) elaborated on how breastfeeding contributes to the different pillars of food security and discussed how it is available, constitutes a

sufficient and accessible form of nutrition for infants less than six months, and is stable. During emergencies, breastfeeding would alleviate the already existing forms of food shortage and contribute to food security.

Emergencies are a source of stress for both the mother and the child and breastfeeding has been shown to contribute to alleviating the resulting stress. Gribble et al. (2011) emphasised that breastfeeding improves responses to stress in both infants and mothers leading to improved coping mechanisms during emergencies. The increase in the level of oxytocin produced with breastfeeding, may play a role in alleviating the stress response.

According to ENN, recommendations for adequate infant and young child feeding during emergencies are similar to the ones during non-emergency situations (Box 2-1). The aim of the recommendations is to ensure proper health and minimise risks for malnutrition, morbidity and mortality during emergencies (ENN, 2011).

1- *Early initiation of breastfeeding:* introducing breastfeeding within one hour of birth.
2- *Exclusive breastfeeding:* infants receive only breast milk for the first six months of life and no other liquids or solids, not even water, with the exception of prescribed vitamins, mineral supplements or medicines
3- *Continued breastfeeding*: sustaining breastfeeding for two years or beyond.
4- *Complementary feeding:* age-appropriate, adequate and safe solid or semi-solid food is provided in addition to breast milk. The complementary feeding period extends from six months to two years of age. Appropriate complementary foods are those that provide sufficient energy, protein and micronutrients through adequate amount, consistency and diversity to meet the child's growing nutritional needs.

Box 2-1 Recommendations for adequate infant and young child feeding in emergencies

Section 2.4 Infant and Young Child Feeding Practices in Lebanon

Lebanon is a country of 10,452 square meters located on the east of the Mediterranean Sea in western Asia with an estimated population of four million of whom 50.6% are female (Central Administration for Statistics [CAS], 2012).

National figures in Lebanon indicate that infant mortality rate is 9 per 1000 live births, under-five mortality rate is 10 per 1000 live births (Central Administration for Statistics [CAS] & UNICEF, 2009) and maternal mortality rate is 86.3 per 100,000 live births (Pan Arab Project for Family Health [PAPFAM] & Central Administration of Statistics [CAS], 2004). Infant and under-five mortality rates have decreased significantly in the last decade; 20 and 21.2 per 1000 live births in 1999 respectively. Similarly, maternal mortality rates have dropped from 140 in 1990 to 86.3 (PAPFAM & CAS), to 18 in 2012 (MoPH, 2015a). It is worth noting that Lebanon experienced a 15-year war from 1975 to 1990, which may account for some of the trend in mortality rates during this period. The latest UNICEF State of the World Children report reported a substantial decrease in indicators, with under-five mortality rate deceasing from 63 in 1970 to 8 in 2015; an annual reduction rate of 5.9% (UNICEF, 2016b).

Lebanon, similar to many countries in the Middle East, is experiencing a double burden of malnutrition with obesity at one end of the spectrum and under-nutrition at the other. Even in children under-five, this double burden is apparent. PAPFAM & CAS (2004) reported stunting to be 11.5% in children under five years of age. At the same time, the prevalence of overweight and obesity amongst preschool children was

reported to be 16.7% (PAPFAM & CAS), a rate that is similar to that in developed countries.

The most recent published national figures on breastfeeding in Lebanon are available in the World Breastfeeding Trends Initiative (IBFAN, 2010) which relies on the 2004 Lebanon Pan Arab Project for Family Health – a household survey - (PAPFAM & CAS, 2004) and the 2009 Multiple Indicator Cluster Survey (MICS) which is a standard UNICEF- developed survey (CAS & UNICEF, 2009). Although the MICS survey is adopted by the Lebanese Government, however, the Lancet series, when reporting on breastfeeding, indicated that MICS in Lebanon was not nationally representative (Supplement to Victora et al., 2016). In addition, a range of individual studies have been undertaken on breastfeeding in Lebanon presented below and summarised in Appendix 1 (Al-Sahab et al., 2008; Batal, Boulghourjian, & Akik, 2010; Batal, Boulghourjian, Abdallah, & Afifi, 2006; Hamade, Chaaya, Saliba, Chaaban, & Osman, 2013; Khayat & Campbel, 2000; Batal & Boulghaurjian, 2005; Nabulsi 2011; Nabulsi, 2014; Osman, El Zein, & Wick, 2009; Zurayk & Shedid, 1981, 1982). Recently, preliminary results of a national baseline survey conducted by UNICEF and including breastfeeding indicators, were presented during an inter-agency meeting. Results are available within the minutes of that meeting however, no formal report has been published (UNICEF, 2016a).

The following is a summary of the main findings related to initiation of breastfeeding, rates of exclusive breastfeeding, duration of breastfeeding, complementary feeding and the main factors influencing breastfeeding in Lebanon compiled from the

different references. Overall, the findings suggest that whilst the rate of initiation is relatively good, continuation is poor and exclusive breastfeeding is low.

The WBTi reported, based on the national MICS3 2009, that initiation of breastfeeding is 41.3% one hour after birth, 17% one to three hours after birth, 15.1% three to six hours after birth, and 25.9% six hours after birth in Lebanon (CAS & UNICEF, 2009; IBFAN, 2010). Similarly, Batal & Boulghaurjian (2005) and Batal et al. (2006) reported, through data collected from 830 mothers, that 18.3% of mothers started breastfeeding within half an hour, 55.9% within a few hours after birth, and 21.2% a few days after birth. 4.6% of respondents reported never breastfeeding their infants (Batal & Boulghaurjian, & Batal et al.). Although the study recruited mothers from Ministry of Social Affairs (MoSA) health centres in six provinces around Lebanon, the sample may not be nationally representative of the Lebanese population given that MoSA works with families who are most disadvantaged (socialaffairs.gov.lb).

According to PAPFAM & CAS (2004), the rate of exclusive breastfeeding at six months is 2%, 7.6% between four and five months, and 24.5% between birth and three months of age. Similarly, CAS & UNICEF (2009) reported that the rate of exclusive breastfeeding is 2% at six months and 40% between zero and one month. The survey showed a big difference between less developed rural areas (30.4% in the north) and urban suburbs of the capital (0%). In addition, 14.8% of infants 0-5 months of age were exclusively breastfed at the time of the survey (CAS & UNICEF). Reported rates of exclusive breastfeeding have been evaluated through the WBTi report and Lebanon has been categorised as being at the lower end of the spectrum compared with other

countries (IBFAN, 2010; IBFAN, 2016). Batal & Boulghaurjian (2005) and Batal et al. (2006 & 2010), reported that 10.1% of the studied sample exclusively breastfed at six months, 23.4% at four months, and 52.4% at one month. As noted above, the study may not be representative of Lebanese women in general. Hamade et al. (2013), while examining the determinants of breastfeeding amongst first time mothers in Lebanon, reported exclusive breastfeeding to be 27.4% (n=452). They reported on data from women as part of a breastfeeding promotion RCT in Beirut only. Recently, preliminary results from the UNICEF baseline survey showed that 24.8% of infants less than six months were exclusively breastfed at the time of the survey (UNICEF, 2016a). Although data are preliminary at this time, this rate is higher than the 14.8% reported in 2009 and might be an indication that rates are increasing.

Breastfeeding duration and continuation were reported by a number of studies. According to the WBTi the median duration of breastfeeding is 11 to 12 months (CAS & UNICEF, 2009; IBFAN, 2010). Also, PAPFAM (2004) reported a mean duration of breastfeeding of nine months. Other studies varied in their results depending on the age of targeted infants and young children. In 1981, Zurayk & Shedid reported that mixed feeding (referred to as breastfeeding with any other food or drink) duration ranged from 7.1 to 11 months. Batal & Boulghaurjian (2005) reported that 41% of women stopped breastfeeding within six months or less (Batal & Boulghaurjian). In 2010, Saade, Barbour, and Salameh, reported an average length of breastfeeding of 4.7 months, and Nabulsi (2011) reported that 35% of women continued breastfeeding until 1 year. Recently, preliminary results from the national survey conducted by UNICEF showed that the median duration of breastfeeding amongst children aged 0

to 35 months was 9.3 months and the percentage of children with continued breastfeeding at two years of age was 20.1% (UNICEF, 2016a).

Complementary feeding practices have been examined by few studies. CAS & UNICEF (2009) reported that 34.1% of breastfed infants four to five months of age and 11% of breastfed infants two to three months of age were receiving complementary food. Also, 41.8% of breastfed infants 6-9 months of age were receiving complementary food (CAS & UNICEF). Batal et al. (2010) also examined complementary feeding and the timing and types of foods introduced to infants. The study conducted on 830 women, found that the majority (78.2%) of infants were introduced to solids at or after four months of age. 25.3% introduced food at or after six months (13.4% at six months) (Batal et al.).

Barriers to breastfeeding have been examined through a number of studies. The main factors that were reported to have a positive association with breastfeeding included: residence in rural area (Batal et al., 2006 & 2010; CAS & UNICEF 2009; Zurayk & Shedid, 1981), mother born in rural area (Batal et al., 2010; Zurayk & Shedid, 1981; Zurayk, Tawil, & Gangarosa, 1982), lower educational level of mother (Al-Sahab et al., 2008; CAS & UNICEF, 2009; PAPFAM & CAS 2004; Zurayk & Shedid, 1981), hospital practices such as the ten steps for the Baby-Friendly Hospital Initiative (Batal & Boulghaurjian, 2005; Batal et al., 2010, 2006), vaginal delivery (as opposed to caesarean delivery) (Batal & Boulghaurjian, 2005; Batal et al., 2006), mother not employed (Batal & Boulghaurjian, 2005; Hamade et al., 2013), mother was breastfed herself (Batal &

Boulghaurjian, 2005), maternity leave (Saade et al., 2010), cared for by female paediatrician, being Muslim and younger age of mother (Al-Sahab et al., 2008).

In addition to the PAPFAM & CAS (2004) and CAS & UNICEF (2009) national surveys, Al-Sahab et al. (2008), Batal & Boulghaurjian (2005), Batal et al. (2006, 2010), Zurayk & Shedid, (1981), and Zurayk et al., (1982), all found that mothers with lower educational level had a higher rate of breastfeeding than women with higher education. Batal et al. (2006) found that mothers who had an educational level lower than intermediate level were three times more likely to exclusively breastfeed for six months than those with higher education. In 2010, Saade et al. reported a relationship between breastfeeding and the duration of maternity leave (and other logistical support for the mother such as time relief and presence of nurseries at work). Al-Sahab et al. reported that whilst most families seek advice and guidance from their paediatrician on infant care after delivery, having a male paediatrician was associated with lower rates of breast-feeding at four months. Hamade et al. (2013) examined the determinants of breastfeeding amongst an urban Lebanese population while implementing a 24-hour hotline and postpartum support film on postpartum stress. The study, which analysed data from an interventional RCT, showed that women who intended to breastfeed, used the video and/or the hotline and were more likely to breastfeed. Implying that intention to breastfeed was a determining factor. Similarly, Nabulsi et al. (2014) piloted a complex breastfeeding support intervention that includes education, professional lactation support and peer support to show that such assistance can strengthen breastfeeding practices.

Section 2.5 Lebanon During the Refugee Crisis - Case Context

2.5.1 The Refugee crisis.

Since its independence in 1943, Lebanon has had its share of emergencies and crisis situations including a 15-year civil war (1975-1990) and the 2006 Israel war on Lebanon. In 2011, civil war erupted in neighbouring Syria, which led to the displacement of a large number of refugees from Syria to Lebanon. From 2012 till the end of 2015, Lebanon welcomed more than 1.2 million Syrian refugees registered with the United Nation High Commissioner for Refugees (UNHCR) (UNHCR, 2017). By the end of 2016, the Government of Lebanon (GoL) estimated that the country was hosting around 1.5 million refugees, making Lebanon the country with the highest per capita refugee population (a quarter of all those in Lebanon are refugees) (GoL & UN, 2016), and the country having the second largest number of refugees in the world (Kelley, 2017). As of autumn 2017, there are 1.017 million registered Syrian refugees with UNHCR in addition to 31,502 Palestinian refugees from Syria, 35,000 Lebanese returnees, and a pre-existing population of more than 278,000 Palestine refugees in Lebanon (UNHCR, 2017). In addition to the refugees, Lebanese vulnerable populations are also affected. According to the UNHCR, nearly half of those affected by the crisis are children and adolescents. It is estimated that 1.4 million children under 18, including Lebanese, Syrians, and Palestinians, are affected. Since the GoL has not permitted the establishment of formal camps, most refugees in Lebanon are living in urban areas and a small percentage are living in informal tented settlements (UNHCR, 2015b). Refugees are dispersed across the country in over 1,700 localities and within the different regions (Beirut/Mount Lebanon, North, South, Bekaa) (UNHCR, 2017). Refugees living in urban areas mostly live in unequipped facilities such as garages,

unoccupied small stores, unfinished buildings, or building entrance. These are most of the time unequipped with kitchen or bathroom facilities (UNHCR, 2013).

The presence of refugees has created significant demands on Lebanon's infrastructure, including its health care system (Cherri, González, & Delgado, 2016). Lebanon has been known for its high quality health care, however, since the start of the crisis, primary health gaps have been identified. Services which provide assistance to refugees and vulnerable Lebanese are overburdened by high demand. In 2015, a 50% increase in health care utilisation was reported since the start of the crisis (GoL & UN, 2017).

There are more than 800 health clinics in Lebanon and the Ministry of Public Health (MoPH) holds an administrative link with around 220 primary health care centres (PHCCs) which form the backbone of Lebanon's National Network of PHCCs (NNP). Some of these centres are supported by government-contracted local organisations. In addition, around 70 centres are operated by the MoSA (mosa.gov.lb). There are also around 100 privately owned centres that are neither within the MoPH nor the MoSA that also provide primary care through dispensaries supported by local grassroots organisations (MoPH). All PHCCs charge a small fee for consultations except for routine vaccinations which are provided by the government free of charge. At the same time, there is predominance of the private sector in health care despite gaps in leveraging it for the provision of care for refugees (Hammoud & El-Jardali, 2014).

As part of the response for the needs of refugees in Lebanon and vulnerable host communities, the main actors consist of the MoPH, UNHCR, WHO, and local and international humanitarian organisations (GoL & UN, 2016). Through different actors, primary health care has been provided primarily through the NNP although some responding organisations are providing services through mobile units or private health centres which are not part of the NNP. The UNHCR, whose mandate is to support refugees, has agreements with 35 PHCCs as well as mobile medical units and hospitals to provide refugees with access to health services (UNHCR, 2015b). Services are provided to refugees with a minimal subsidised fee however, cost remains a main barrier to access services (Benage, Greenough, Vinck, Omeira, & Pham 2015). Reports on health access and utilisation amongst Syrian refugees in Lebanon showed that 70% of women aged 15-49 years and who have been pregnant in the past two years reported accessing antenatal care (ANC), a decrease from the 85% in 2015 (GoL & UN, 2017). Reports concluded that most refugees were aware of the life-saving care and deliveries but were less aware of the primary health care services. Access to primary health care, including that of pregnant women, was evaluated as good. Financial barriers to access of health care were highlighted where 16% of Syrian refugees who required health services were not able to do so for cost reasons (Lyles & Doocy, 2015; UNHCR, 2016b). None of the reports examined access to health education such as breastfeeding education but it was reported that 75% of new mothers said they breastfed (Lyles & Doocy).

2.5.2 Nutrition, food security and IYCF practices and health during the Syrian crisis.

Since the start of the Syrian crisis, assessments have been conducted to evaluate the nutritional status of refugee children under five years of age including feeding practices. Two inter-agency (UNICEF, UNHCR, WFP, WHO) nutrition assessments were conducted in 2013 and 2014 reporting on nutrition and IYCF indicators (Hossain, Leidman, Kingori, Al Harun, & Bilukha, 2016; UNICEF et al., 2013; UNICEF et al., 2014). Starting 2013, and on a yearly basis, the World Food Programme (WFP) and other UN agencies conducted the Vulnerability Assessment for Syrians in Lebanon (VASyr). This assessment included indicators for food security, malnutrition and IYCF practices. Table 2-1 in this chapter summarises the main indicators related to IYCF as well as acute malnutrition from the VASYr and other interagency surveys.

The reports highlight gaps in food security and report that more than 94% of the Syrian refugee population as having some degree of food insecurity with this percentage increasing by 4% between 2015 and 2016 (UNHCR, UNICEF, WFP, 2015; UNHCR, UNICEF, WFP, 2016).

Table 2-1 IYCF and malnutrition indicators amongst Syrian refugee children in Lebanon

Indicators	***2013***	***2014***	***2015***	***2016***
Exclusive breastfeeding below 6 months (VASyr)	-	-	45%	58%
Exclusive breastfeeding below 6 months (Inter-agency)	-	25%		
Breastfeeding[5] 6-11 months (VASyr)	74%	80%	71%	65%
Breastfeeding 12-17 months (VASyr)	49%	45%	57%	52%
Breastfeeding 18-23 months (VASyr)	26%	24%	-	17%
Breastfeeding 6-23 months (VASyr)	51%	52%	64%	45%
Consumption of infant formula under 6 months (VASyr)	-	-	22%	-
Consumption of infant formula 6-23 months (VASyr)	40%	21%	33%	28%
Minimum dietary diversity[6] 6-11 months (VASyr)	6%	3%	7%	4%
Minimum dietary diversity 12-17 months (VASyr)	18%	24%	14%	14%
Minimum dietary diversity 18-23 months (VASyr)	25%	28%	-	27%
Dietary diversity 6-23 months (VASyr)	16%	18%	10%	18%
Minimum acceptable diet 6-12 months (VASyr)	3%	2%	4%	3%
Minimum acceptable diet 12-17 months (VASyr)	9%	6%	2%	3%
Minimum acceptable diet 18-23 months (VASyr)	12%	4%	-	3%
Minimum acceptable diet 6-23 months (VASyr)	4%	4%	3%	3%
Global Acute Malnutrition Boys (VASyr)	2.8%	-	-	2.9%
Global Acute Malnutrition Girls (VASyr)	1.6%	-	-	1.6%
Global Acute Malnutrition total 6-59 months (VASyr)	2.2%	-	-	2.3%
Global Acute Malnutrition total 6-59 months (Inter-agency)	4.4%	2.2%	-	-

[5] Refers to breastfeeding one day prior to the survey.

[6] As defined in WHO (2008).

Syrian refugees who are registered with the UNHCR receive a food voucher that they can use to purchase food. In 2015, the WFP was forced to reduce its voucher value due to severe funding gaps. Even though the voucher value was increased in 2016, food security indicators remained poor with access to food a persistent issue affecting dietary diversity and food consumption (UNHCR et al., 2016).

In terms of IYCF and as in Table 2-1, breastfeeding rates are increasing slightly, however complementary feeding indicators remain very poor, and rates of acute malnutrition rates have not changed. The gaps in food security and dietary diversity, especially amongst children under two years of age, is still a concern. There are differences between breastfeeding indicators collected from VASyr (UNHCR, UNICEF, WFP, 2013; 2014; UNHCR et al., 2015; 2016) and those collected through the inter-agency survey (UNICEF et al., 2013; UNICEF et al., 2014) possibly due to the indicator definitions. Still, the rates of exclusive breastfeeding are considered low.

In addition to the VASyr, in 2016, the UNICEF national survey was conducted to assess the situation in Lebanon. The survey included IYCF indicators and preliminary results showed that 33.5% of children six months of age were breastfed and that 50% of children 0-23 months of age were bottle fed (UNICEF, 2016a). The report included children of all nationalities within Lebanon. Additional figures related to breastfeeding are shown in Table 2-2 of this chapter including a comparison of practices amongst the different nationalities. The survey included more than 23,000 households,

however, preliminary results presented did not include the sample size of surveyed children under two years or under five years of age.

Until the time when this research was undertaken, the results of the above survey were still preliminary and not formally published. Still, both percentages from the national survey and the VASyr survey do show that IYCF indicators amongst Syrians in Lebanon are better than those amongst Lebanese.

In addition to nutrition and feeding practices, reports highlight the burden of disease amongst children under five years of age. UNHCR et al. (2015) reported that of the more than 4,000 children under five years of age surveyed, over 37% were ill in the two weeks prior to the survey, and coughing was the number one reported symptom followed by diarrhoea (25%) and fever (4%) indicating communicable diseases. The percentage was similar to that reported in UNICEF et al. (2014) where 25% of children under five years of age experienced diarrhoea in the two weeks prior to the survey (n=1500). Other infectious diseases have been found to present a threat given the increase in population, crowding, and absence of clean water and poor sanitation (GoL, 2016).

Table 2-2 IYCF indicators as reported in the 2016 national survey – preliminary results

Practice	**% Lebanese children**	**% Syrian refugee children**	**% Palestinian Refugees in Lebanon**	**% Palestinian Refugees from Syria**
% exclusive breastfeeding under 6 months[7]	24.8%	33.5%	26.2%	21.2%
% predominant breastfeeding under 6 months[8]	34.2%	62.1%	39.9%	40.5%
% Continued breastfeeding at 1 year	36.7%	61.6%	42.9%	47%
% Continued breastfeeding at 2 years	20.1%	36.5%	25.4%	15.3%
Median duration among children age 0-35 months	9.3%	16.3%	10.8%	13.1%
Age-appropriate breastfeeding amongst children age 0-23 months	25%	38.7%	30.8%	31.7%
Bottle feeding	68.4%	50%	53.1%	40.5%

[7] Infants receiving breast milk, and not receiving any other fluids or foods, with the exception of oral rehydration solution, vitamins, mineral supplements and medicines.

[8] Infants who receive breast milk and certain fluids (water and water-based drinks, fruit juice, ritual fluids, oral rehydration solution, drops, vitamins, minerals, and medicines), but do not receive anything else (in particular, non-human milk and food-based fluids).

Section 2.6 Rationale, Aims and Objectives

2.6.1 Rationale.

Given the importance of ensuring IYCF in emergencies and in view of the vulnerability of Lebanon and its prevalent poor feeding practices, it is important to ensure that IYCF is upheld in the current and any future emergencies. Very few investigations have been conducted in Lebanon in relation to IYCF-E and whether provisions have been made to ensure that IYCF is supported and appropriate practices are promoted in emergencies. A review of the literature shows that the main publications documenting lessons learned from past experience on IYCF-E in Lebanon relate to those published by MacLaine following the July 2006 war in Lebanon (MacLaine, 2006). A report published by Save the Children UK in 2007 summarises findings of an assessment of IYCF in Lebanon after the end of the one-month long conflict in Lebanon. The key findings of the report include:

- A lack of awareness of available IYCF-E guidance such as the Operational Guidance on Infant and Young Child Feeding in Emergencies (OG-IYCF-E) and the International Code of Marketing of Breast Milk Substitutes (the Code) which led to the blanket distribution of infant formula.
- A lack of commitment from international organisations and UN agencies to the Code and OG-IYCF-E including staff and partners of the latter.
- A lack of support for mothers to continue breastfeeding during and after the conflict.
- Infant feeding not being on the priority list of lead agencies.

A key finding by MacLaine (2006, p. 9) was that "policies were not enforced among field staff by Head Office/INGOs[9]", which indicates the presence of policies but absence of enforcement. The report included recommendations that were proposed to ensure adequate preparedness such as the importance of implementing capacity building on issues related to IYCF-E, the engagement of policy makers and key agencies in prioritising IYCF-E, and integrating IYCF-E activities within existing programs.

Also in 2006, Obeid reported, through the administration of a survey questionnaire to organisations responding to the emergency, that 50% of the surveyed NGOs (n=28) distributed infant formula and the majority did so through mass or blanket distribution.

Eleven years after the last emergency and as the Syrian refugee crisis progressed, few reports have documented the challenges in IYCF-E. Darjani & Shaker-Berbari (2015) documented their observed challenges in IYCF-E including the lack of support to mothers as well as challenges in supporting artificially fed babies. Rizkallah (2015) emphasised the need to strengthen IYCF practices through increasing community awareness and mobilisation. Seguin (2015) reported on the main challenges in IYCF during the refugee crisis including the influence of family members on mothers, the conflicting messages by health care providers (HCPs), and the high rates of artificial feeding amongst the Syrian population compared to rates in other emergencies (for example in Africa). Seguin also mentioned the untargeted distribution of BMS in

[9] International Non-Governmental Organisations.

informal tented settlements (ITSs). Mboya (2015) documented regional challenges; she highlighted gaps in translating policy into practice and that despite efforts to further IYCF, the effect of the infant formula industry is still apparent. Even in non-refugee settings, it has been reported by a recently established NGO for the support of breastfeeding that mothers receive little support related to breastfeeding be it in hospital, primary health, or community settings in Lebanon (LACTICA, 2017).

The OG-IYCF-E recommends that organisations and governments have provisions set in place to support IYCF in emergencies including policies to protect, support, and promote IYCF-E (IFE Core Group, 2007). This is in an attempt to ensure preparedness for emergencies. Little is known about existing policies in Lebanon related to IYCF or IYCF-E. Akik, Ghattas, Filteau, and Knai, (2017) recently reported gaps in IYCF policy implementation including lack of support for breastfeeding amongst health care professionals. There is therefore a need to further investigate the extent to which Lebanon has policies and programmes in place to support IYCF in emergencies.

2.6.2 Aims and objectives.

The aim of this research is to conduct a situational analysis of policies and programmatic activities related to infant and young child feeding during emergency situations in Lebanon in order to provide a basis for emergency preparedness for this and future crises.

The objectives of this research are:

1. To review and critically evaluate the content of current policies and practice based guidance related to IYCF in emergency situations in Lebanon with respect to concordance with international recommendations.
2. To identify and critically evaluate current implementation of policies and programmatic activities related to IYCF in emergency situations operational in Lebanon with respect to concordance with international recommendations.
3. To identify barriers to implementation of national and institutional policies and programs related to IYCF in emergency situations in Lebanon that comply with international standards.
4. To explore plausible approaches and opportunities to guide the development of effective policies and programmatic activities that optimise IYCF in emergency situations in Lebanon.

Chapter 3 METHODS AND METHODOLGY

This chapter presents a detailed description of the research methodology including the different steps undertaken to conduct the research. The chapter is divided into five sections starting with the research paradigm and methodology and ending with ethical considerations.

Section 3.1 Research Paradigm and Theoretical Underpinning

In research, it is important to acknowledge the way the researcher and the research process have shaped the research methodology, methods and structure of analysis (Denzin & Lincoln, 2011, p. 12; Tuli, 2008). Whether consciously or not, the research is often shaped by a theoretical and philosophical underpinning that shapes the methodology of the research. The selection of different methods will also depend on the methodology used as well as the paradigm adopted which is always led by the research objectives (Richards & Morse 2007). The illustration below (Figure 3-1) is a depiction of the different pieces of a research foundation or paradigm as adapted from Tuli (2008).

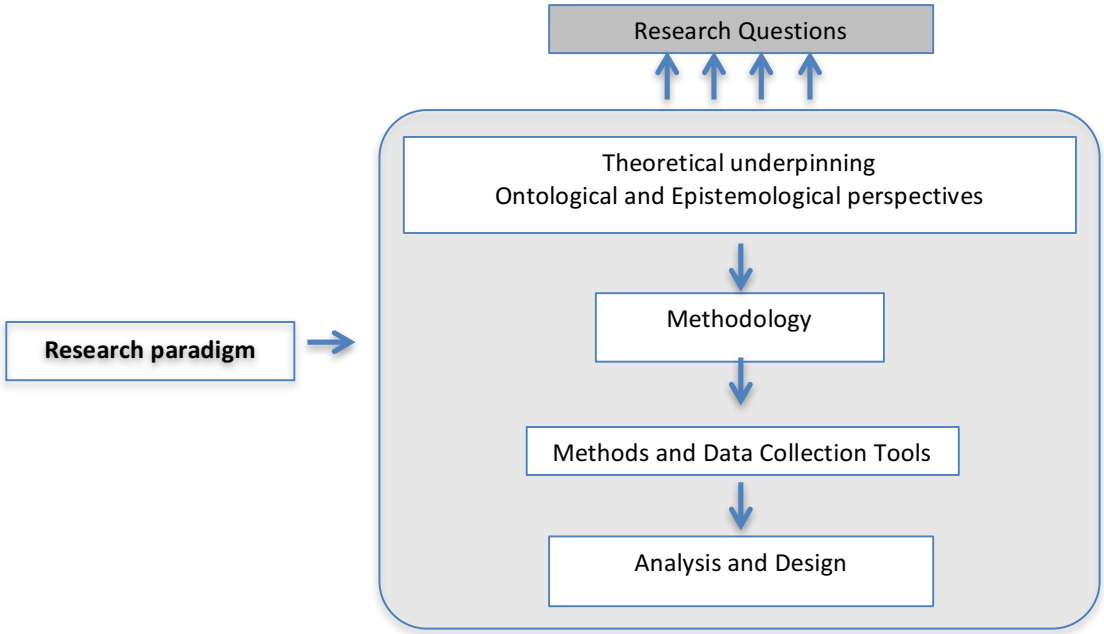


Figure 3-1 Research paradigm

A theoretical underpinning relates to the nature of the reality being studied (ontology) and how knowledge about reality within the research is acquired (epistemology) (Petty, Thomson, & Stewa, 2012). There are different research paradigms or worldviews as described by Creswell (2009). These form the philosophy behind qualitative research (Creswell, 2013), the different ontological and epistemological assumptions, but also the overall methodology used.

Epistemology refers to the researcher's understanding of what constitutes knowledge. It asks questions such as "what is the relationship between the knower and what is known?", "how do we know what we know?" and "what counts as knowledge?" (Tuli, 2008). The epistemological approach looks at how knowledge about the reality is

obtained. Ontology on the other hand is defined as the belief about reality, whether the researcher believes there is a single reality or not (Petty et al., 2012).

The most common theoretical approaches described are the positivist and interpretivist (also known as social constructivism) paradigms (Denzin & Lincoln, 2011; Petty et al., 2012). The positivist approach claims that there is only one reality and is often referred to in quantitative research (Tuli, 2008). The reality is external to the researcher – i.e. an objectivist approach. On the other hand, much qualitative research belongs to the interpretivist approach, which looks at realities from different perspectives (Tuli). In interpretivism and social constructivism, there is a belief that the reality being researched is constructed within the context under study and different realities exist in different contexts. The research is led by the theory that there are different realities and that the latter are socially constructed (Creswell, 2009). Although these are distinct approaches, however, a research study could have a tendency to be more qualitative or more quantitative in nature and therefore more interpretivist or positivist in nature. Critical realism, first originating with Bhaskar in the 1980s, was later described by Denzin and Lincoln (2011) as an alternative to both positivism and interpretivism (Fletcher, 2016). One main belief in critical realism is that ontology or the nature of reality is not limited to epistemology (or the knowledge of that reality). Critical realism acknowledges that the truth exists independently of social actors but understands that human knowledge captures a part of this reality (Archer, Bhaskar, Collier, Lawson, & Norrie, 2013). In critical realism, reality is stratified into three levels; empirical, actual, and real and using multiple research methods is important to reach each of these layers (Archer et al., 2013). Figure 3-2 is an

illustration of the three levels of realities which shows that the empirical is knowledge about what is perceived through observation, the actual is the reality that is experienced and is actually happening, and the real is considered the truth which reveals the mechanisms behind how and why phenomenon are happening.

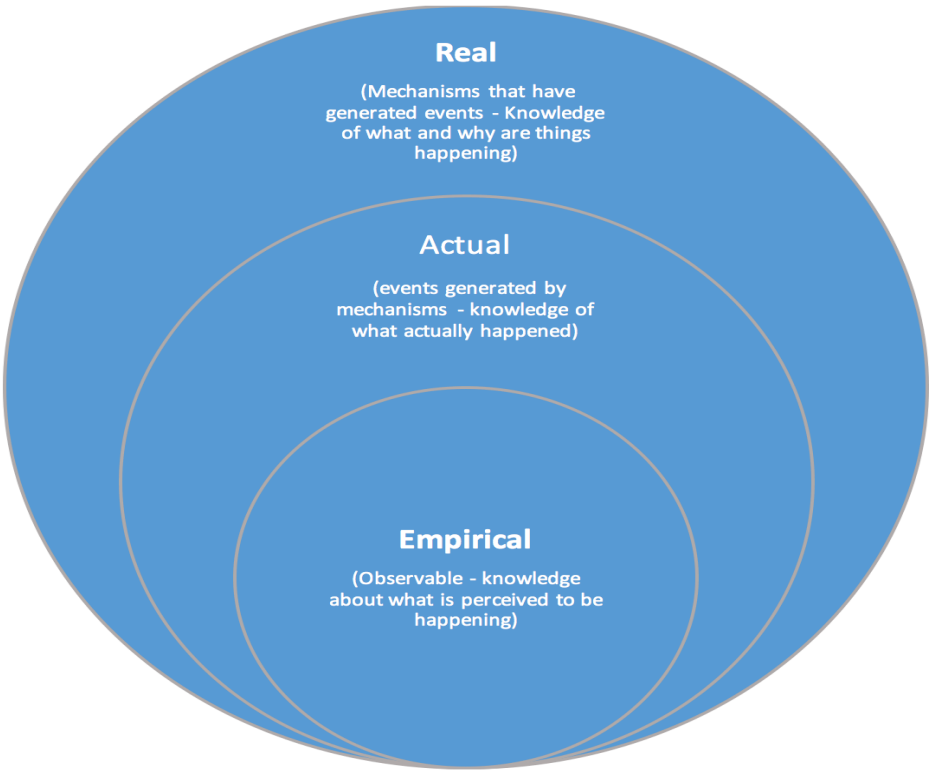


Figure 3-2 Critical realism different levels of realities (Adapted from Larsen and Eargel, 2015 and Alexander, 2013)

Critical realism allows the researcher to make causal inferences about mechanisms in order to ultimately reach the reality about a certain phenomenon. It acknowledges the importance of building on existing knowledge and progressively constructing knowledge through multiple research methods (Fletcher, 2016).

For research on health policy, there is often a lack of consensus about the ontological and epistemological underpinnings to be adopted (Gilson, 2012). However, Gilson (2012) and Maxwell (2012) described critical realism as a paradigm that is used for health policy research. Marchal, Dedzo & Kegels (2010) point out that a critical realist approach used in health policy research will help in building upon existing knowledge and provide information that allows decision-makers to know how to improve performance. They used critical realism to evaluate the impact of a particular hospital management approach on performance and linked, using critical realism, policy to practice and examined what worked and when. Critical realism also allows the search for causation to help explain social events and suggest practical policy recommendations to address social problems (Fletcher, 2016). Gilson (2012) point out that critical realism allows to investigate mechanisms underpinning social phenomena (such as health policies and systems). Fletcher (2016) highlighted that critical realism functions as a framework to guide methodology but is not specific for any particular methodology. He used critical realism to examine how major changes in agricultural policy affect farm women's work and to suggest policy recommendations. Therefore, critical realism seeks to identify causal mechanisms although these may not hold across contexts and times (Gilson, 2012).

In terms of this research, the theoretical approach is most accurately described as the critical realist view. This research seeks to examine preparedness in IYCF-E within the identified health policies and activities while taking into consideration the links and influences related to actors and contexts. It will use a mix of both qualitative and quantitative research tools and methods as a way to uncover the reality about

preparedness. The researcher acknowledges the existence of knowledge about preparedness related to IYCF through existing policies and activities. At the same time, there is an acceptance that knowledge is also produced through the lens of the interviewees' own perceptions. The research will seek to understand the perspectives of different actors in different contexts to construct the knowledge and reality within a particular context. The study will consist of an analysis of multiple perspectives and interactions, including that of central level, organisational level, and service provision level as described in Section 3.2. In doing so it will help to produce an understanding of policies on IYCF-E in Lebanon, explore possible opportunities and mechanisms for improvement, and examine the phenomenon of preparedness.

In addition to the theoretical underpinning and adopting critical realism, it is important to acknowledge how the identity of the researcher may have played a role in shaping the research as this will increase the validity of the research (Merriam, 2009). See Chapter 8, Section 8.5.1 'Role of the researcher'.

Section 3.2 Methodology – Case Study

A methodology is an approach or strategy that guides a set of procedures (Creswell, 2009; Denzin & Lincoln, 2011). As defined by Kelly (2010), in qualitative research, a methodology highlights the rationale behind how the research will be conducted, guides how data are collected and how findings are analysed. A methodology will ensure that all components of the research "work harmoniously together", and will help the research "to safely and efficiently reach its destination" (Maxwell, 2005).

There are different qualitative research methodologies and selecting one depends on the research objectives and questions asked (Richards & Morse, 2007).

This research uses a Case Study methodology which consists of conducting an in-depth study of a case (or multiple cases) within a real context (Yin, 2012). As Crowe et al. (2011) summarises it, the Case Study approach allows the researcher to answer questions such as 'how' and 'what'. In health policy research, Case Study methodology is a design that is often used (Prior et al., 2014). Critical realism is also well suited for Case Study research (Easton, 2010) as it provides the platform for the use of multiple forms of data collection essential for seeking to understand the reality of the phenomenon under study. In the current research, objectives are related to the 'what' in terms of policies and programmatic activities as well as barriers and opportunities to implementation. The study is a situation analysis of policies and programmatic activities, answering 'what' is happening and 'how' are policies implemented. Therefore, the Case Study is exploratory and descriptive in nature (Baxter 2008; Gilson, 2012; Yin, 2003, Yin 2014). According to Baxter, this method is of great value for research in health sciences and is useful in evaluating programmes because it is flexible and rigorous at the same time.

3.2.1 Rationale for using Case Study methodology.

More than one methodology might have been chosen for this research. For example, in phenomenology, the study of how individuals experience a phenomenon, the methodology is focused on answering the question related to the lived experience of this phenomenon by an individual or by many individuals (Creswell, 2013). In

particular, McConnell-Henry, Chapman, and Francis (2009) examines phenomenology from the nursing perspective and describes that it offers “an insightful means for understanding nursing phenomena in relation to lived experiences”. He explains that the topic of study is patient experiences. Petty et al. (2012) described the focus of phenomenology as “understanding the unique lived experience of individuals by exploring the meaning of a phenomenon”. One could argue that the current research includes an aspect that relates to lived experiences in relation to mothers or end users. However, since the phenomenon in question is preparedness and the research is looking at policies and activities at different levels of implementation within Lebanon, the phenomenology would not offer a fitting approach to address the research objectives.

The other methodology to consider is grounded theory which consists of developing a “bottom-up” theory that is “grounded” in the empirical data (Greene & Browne, 2005). The theory serves to explain action, interaction, or process. Grounded theory is usually used to generate theory as well as to test or elaborate upon previously grounded theories (Creswell, 2013). When it comes to the research in question, grounded theory may not be the best choice as the research question is not related to the development of a theory but rather to a phenomenon. In addition, as mentioned before, in order to address the research objectives there is a need to include different sources of evidence and the grounded theory methodology does not provide a space for that.

On the other hand, there are multiple justifications for the use of the Case Study research methodology in the current research. First, the research consists of exploring policies and programmatic activities and the extent to which these are sufficient to ensure emergency preparedness in relation to IYCF. According to Yin (2014) the "why" is important for doing Case Study research and this research is not only exploring existing policies and activities but also examining why they are functional or not i.e. the barriers and opportunities and "how" they can work best to ensure emergency preparedness. Second, the Case Study approach is appropriate to the understanding of the existing gaps in delivery of certain interventions (Yin, 2003) thus refining or developing interventions. In this research, gaps in policies and activities are examined in order to provide plausible approaches for improved policies and programmes. Third, one of the main characteristics of Case Study research is the use of multiple sources of information (Yin, 2014). Creswell (2013) also described the Case Study methodology as an exploration of a case through in-depth data collection involving multiple sources of information. In this research, in order to explore the different levels of policy and activity implementation, the use of multiple data collection tools and sources of information provides a more robust approach and renders the Case Study methodology relevant. Fourth, the Case Study research approach is most appropriate since the current research is exploring a unique phenomenon, which is emergency preparedness, in a unique context, which is Lebanon during the Syrian refugee crisis, using an in-depth investigation. The crisis in Lebanon is a unique and rare opportunity to conduct empirical research. Conducting research during an emergency is often challenging given the competing priorities including those of providing support (Blanchet et al., 2015). Finally, as Yin (2014) indicated, the niche for

conducting Case Study approach is that the research includes questions about a "contemporary set of events" "over which the researcher has little or no control". The phenomenon in question in this research as indicated in the definition of the Case is emergency preparedness in relation to IYCF-E and is being examined outside the control of the researcher. Therefore, given the justifications given above, the Case Study approach was found as most relevant to address the research objectives.

3.2.2 Defining the Case.

The first step in conducting a Case Study consists of defining the Case. A case is defined as an object of study; it is a "bounded entity" that serves as the main "unit of analysis". A case needs to be refined and should have boundaries; otherwise, it will be too broad (Stake, 1995; Yin, 2003). Boundaries may relate to time, place, activity, or definition (Stake; Yin). In this research, the phenomenon of interest was the level of preparedness related to IYCF-E. Therefore, the "Case" consisted of *policies and programmatic activities related to infant and young child feeding in emergencies in Lebanon.*

In terms of selecting the Case, the researcher may want to select a case that represents an extreme example of a phenomenon, or alternatively may want to find an atypical case (Yin, 2014). In this research, the Case was selected essentially since the researcher is interested in the phenomenon (IYCF-E preparedness) in her country, Lebanon. At the same time, although it would have been possible to select another Case – i.e. another country – still the context in which the Case is being examined is particular and the researcher is familiar with it which results in further identification

with the Case. More importantly, Lebanon was experiencing an actual refugee crisis and therefore it was an opportunity - rarely presented to researchers - to conduct the research during the emergency.

The boundaries of the Case were defined geographically – Lebanon – and temporally - between the period of 2012 and 2015. The boundaries of the Case consisted of policies and programmatic activities that existed in Lebanon targeting both Syrian refugees and the local host communities during the indicated period. To note that the definition of the Case was refined throughout the research and as the researcher gained more understanding of the context.

3.2.3 Single-case study design with embedded units of analysis.

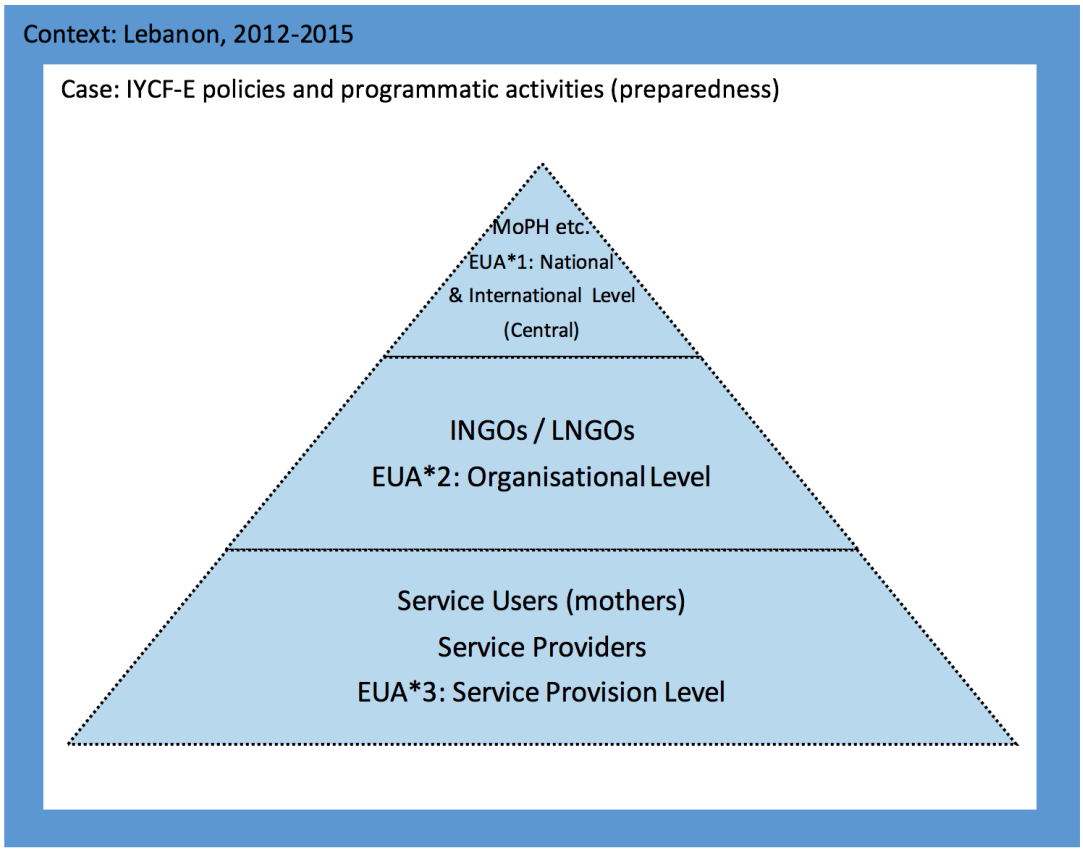
In this research, a single-case study design was used as described by Yin (2014), encompassing one country (Lebanon) and IYCF-E policies and programmatic activities. The examination of the Case includes the engagement of organisations active in Lebanon, key stakeholders engaged in IYCF policy and programmatic activities, service providers and end users (mothers).

Having a single-case design (as opposed to multiple-case design) carries weaknesses, and multiple cases are more likely to increase the validity of the research (Yin, 2014). This relates to the issue of generalisation, i.e. the concern that one cannot generalise from findings of a single example. However, a Case Study also seeks to make inferences at the theoretical level rather than seeking quantitative generalisation. The empirical findings of a single case can be used to identify opportunities for that particular case as it is in the case of this research. It can also be compared with

previously developed theory which will add to its understanding. Chapters 4 through 8 consider the findings of the Case Study in relation to other empirical studies and allow a consideration of the extent to which the findings match those of other studies. In this research, the adoption of a single case design was largely pragmatic. It was not possible for the researcher to examine more than one case as this would mean travelling to more than one country. One might argue that if the definition of the Case was narrowed down to organisational level, this might have given the opportunity to choose more than one case. However, the researcher's interest was to provide a holistic picture of the case of emergency preparedness in Lebanon in relation to IYCF-E without focusing on a few organisations which might give a partial picture.

Yin (2014) explains that within single-case designs, a Case Study can have two potential designs; a holistic single-unit of analysis or an embedded multiple units of analysis. In the embedded multiple units design, the study includes a single case however attention is also given to different units of analysis as it is the case in the current research. As depicted in Figure 3-3 of this chapter, the Case of IYCF-E policies and programmatic in Lebanon is examined in one context; the Syrian refugee crisis in Lebanon. The study includes three units of analysis: central level, organisational, and service provision level. The central level encompasses government or higher management level, organisational level includes the level at which organisations implement initiatives, and service provision level is at the level of providing services and encompasses both service providers and end users (mothers).

Within the realm of critical realism, having multiple units of analysis will allow the building of knowledge about reality. It will allow an exploration of perceptions about that reality at the central and service provider level as well as actual actions at the central, organisational, and service provision level. Mechanisms related to the "why" (barriers) and "how" (opportunities) will then be explored to provide insight into the reality (Figure 3-2).



*Embedded unit of analysis

Figure 3-3 Single-case study design with embedded multiple units of analysis (Based on Yin 2014)

Section 3.3 Methods

The research uses a mix of both qualitative and quantitative data collection tools in order to address the research objectives and collect multiple forms of evidence. The

use of different methods of data collection is desirable to strengthen the construct validity of the Case Study (Yin, 2014). The methods include a document review, semi-structured interviews, a survey questionnaire, and focus group meetings. The use of different methods is essential within critical realism as it will provide the opportunity to seek knowledge about the different levels of reality.

In order to clarify the purpose behind each of the data collection tools, first, the research objectives were converted into research questions as described in Box 3-1.

Q1: What is the content of current policies and practice based guidance related to IYCF in emergency situations in Lebanon and how does this content compare with international recommendations?

a. What are existing international IYCF-E standards and guidance?
b. What are existing IYCF-E national, organisational, and institutional policies?
c. How do existing policies compare with international guidance?

Q2: Are existing IYCF-E policies and programmes in Lebanon fully implemented and aligned with national policies, practice-based guidelines and international recommendations?

a. What are existing IYCF and IYCF-E initiatives and programmes?
b. Are existing IYCF-E policies fully implemented?
c. Are existing IYCF and IYCF-E programmes aligned with existing guidance?

Q3: What are barriers to implementation of national and institutional IYCF-E policies and programmes in Lebanon?

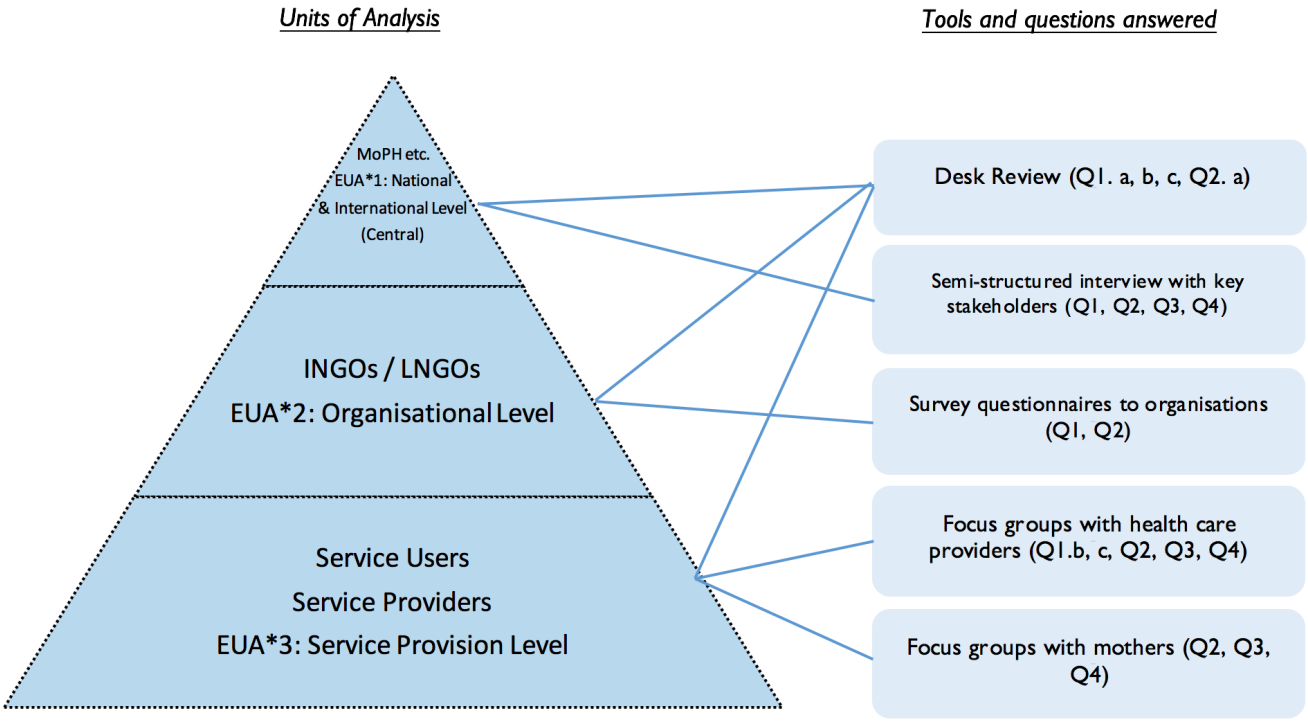
Q4: What are plausible approaches and opportunities that can guide the development of effective policies and programmatic activities that optimise IYCF in emergency situations in Lebanon?

Box 3-1 Research questions

For each of the questions/sub-questions, one or more data collection tools are used.

Figure 3-4 in this chapter is a depiction of the different stages of data collection and

the questions each method is attempting to answer as well as the level each of the tool captures.



*Embedded unit of analysis

Figure 3-4 Methods of data collection

3.3.1 Document review.

The first stage of data collection consisted of a document review which examined the current IYCF-E guidance and policies at the international level and national level as well as programmes at the national level (Chapter 4, Sections 4.1 and 4.2). This stage helped provide information about existing knowledge related to IYCF-E policies and programmes as it is suggested within critical realism.

The questions sought are the following which feed into questions 1 and 2 (Box 3-1 and Figure 3-4):

1- What are international policy guidelines for achieving adequate infant and young child feeding?
2- What are current international operational and programmatic guidance on IYCF-E?
3- What are the main documented gaps in implementation of IYCF-E policies and programmes?
4- What are current documented policies and programmatic activities related to IYCF in Lebanon and to what extent are they aligned with international guidance?

Data sources used for collection of information related to international recommendations and guidelines included UNICEF, WHO, UNHCR, World Bank databases, the ENN, and other UN agencies or international organisations.

The following inclusion criteria were used for selection of international documents:

- The document consists of a convention, a resolution, a declaration, a global strategy, a list of guidance or guiding principles, a global initiative, a global conference, or a global report.
- The document discusses IYCF in normal situations or during emergencies.
- The document was published by a UN agency or an international organisation.

Documents that consisted of training material and manuals and documents that are published by single governments were excluded.

For national policies and guidance, local ministries' websites and databases were used. In some cases, minutes of meetings were also used as reference.

The following inclusion criteria for selection of national policy and guidance documents were used:

- The document is a policy, strategy, guidance note, action plan, law or decree relevant to Lebanon.
- The document discusses IYCF or infant nutrition in normal situations or during emergencies.
- The document is linked to emergencies or the Syria crisis refugee response.
- The document discusses public health.
- The document is published and available.

Documents that were not available online were not accessible and therefore were not used.

Databases used for peer reviewed articles included: Medline, PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane Library, OvidSP (Maternal and Infant Care Database), SCOPUS, TRIP (Turning Research Into Practice), Web of Knowledge.

Search terms used included but were not limited to a single or a combination of the following terms: infant and young child feeding policy, infant and young child feeding guidance, infant and young child feeding programming, breastfeeding policy, nutrition law, nutrition programme, health policy Lebanon, implementation of infant and young

child feeding policy, state of implementation of the international code of marketing of breast milk substitute, etc.

3.3.2 Semi-structured interviews with key stakeholders.

The second method of data collection consisted of conducting semi-structured interviews with key stakeholders in Lebanon.

3.3.2a Purpose of semi-structured interviews.

Semi-structured interviews with key stakeholders were conducted to answer questions 1, 2, 3, and 4 at the central level (Box 3-1 and Figure 3-4). Interviews served as a tool to collect information on national policies and programmatic activities governing IYCF-E in Lebanon. They shed light on current practices related to IYCF-E and barriers for implementation of policies. Interviews are useful since these can provide explanation as well as perceptions. It is one of the main forms of collecting information in a Case Study methodology (Yin, 2014). It is also important within critical realism as it provides knowledge from the perception of stakeholders. However, one must acknowledge the response bias as well as the reflexivity where the interviewee may influence the flow of the interview (Yin, 2014). See Chapter 8, Section 8.2 'Role of the researcher'. Outputs from the semi-structured interviews combined with the desk review, gave insight into the Case at the central level (i.e. the first embedded unit of analysis).

3.3.2b Participants and criteria for selection in semi-structured interviews.

Semi-structured interviews were conducted with key stakeholders involved in executing and setting IYCF and IYCF-E policies and programmatic activities in Lebanon. Eight key stakeholders were initially selected from relevant ministries and organisations. Purposive sampling was used and the following criteria were applied for identifying interviewees:

1) is an official engaged in health related activities during emergencies,

2) is engaged in policy related to emergency relief or health,

3) is available and willing to participate,

4) has been in an official position for more than six years, and

5) has a key position in the institution he/she represents.

Based on these criteria, eight individuals were identified, four of whom were from the MoPH, one from the MoSA, and three from UN agencies or other international organisations. Of the eight who were contacted, seven responded and were interviewed. Throughout the process, interviewees recommended names of other stakeholders deemed useful to meet. Accordingly, six more informants were identified from the Ministry of Economics, UN agencies, a private university, and other organisations. Of the six additionally identified, five were available for an interview. In total, twelve interviews were conducted. The variety in interviewees was essential as it provides different perspectives and enriches knowledge about reality as suggested within critical realism.

3.3.2c Interview guide format and content for semi-structured interviews.

A semi-structured interview guide was used for collection of data from stakeholders. The guide focused on IYCF and IYCF-E policies and programmatic activities in Lebanon (Appendix 2). The content of the interview guide included the following domains: knowledge about available policies and decrees governing IYCF and IYCF-E, perception about implementation of existing policies and guidance, perceived barriers for implementation of policies, current IYCF and IYCF-E programmes and activities, recommendations and aspirations related to IYCF and IYCF-E in Lebanon. The interview entailed open-ended questions as well as further exploration of the topic in greater depth by the use of prompts and probing.

Prior to using the interview guide, it was translated into Arabic, back translated, and tested by the researcher on three independent persons. Translation took into consideration issues related to cross-cultural research (Khalaila, 2013). For example, as it is in many Arabic-speaking countries, in Lebanon, the Arabic written language (which is the formal Arabic) is different than the spoken Arabic (also known as colloquial). Therefore, in order to ensure that the interview guide is well understood by participants, it was administered in colloquial language. The guide was tested on three volunteer interviewees in order to ensure validity, reliability, and flow. It was amended accordingly (Appendix 2).

3.3.2d Procedures for conducting semi-structured interviews.

Invitations were sent to representatives from the above-mentioned entities requesting participation in the study and explaining the objective of the study through a Participant Information Sheet (PIS) (Appendix 2). The PIS included information about

the interviewee's rights and scope of the study. Invitations were followed with a phone call in order to ensure participation. On the day of the interview, participants were asked to provide written consent for participating in the study by filling and signing the PIS.

Interviews were conducted in colloquial Arabic/Lebanese when interviewees were not comfortable speaking in English. In some cases, interviewees would speak in a mix of English and Arabic or predominant Arabic with some English words or vice versa. French words were sometimes used as well. Regardless of the language used, the interview was recorded and transcribed verbatim by the researcher, meaning that the exact words were used in the transcripts. Once transcribed, transcripts were translated into English as described in Section 3.3.6. Once transcribed and translated, transcripts were then analysed using thematic analysis. See section 3.4 'Analysis'.

3.3.3 Survey questionnaire.

The third method of data collection consisted of a survey questionnaire administered to Non-Governmental Organisations (NGOs) intervening in areas related to relief and emergency assistance in Lebanon. The questionnaire, collecting quantitative data, is considered one of the tools used concomitantly with other tools in a Case Study (Yin, 2014).

3.3.3a Purpose of survey questionnaire.

As depicted in Figure 3-4, this stage aimed to answer research questions 1 and 2; to collect information on current organisational IYCF and IYCF-E policies and

programmatic activities as well as past and current practices and experiences. The survey questionnaire was chosen as a tool since it provides the opportunity to access a large pool of organisations; which would have been time consuming with another qualitative data collection tool. Combined with the desk review, information collected provided an examination of the Case at the organisational level. Knowledge sought through the survey questionnaire gave insight onto the actual reality (Figure 3-2), i.e. the actions made by organisations related to IYCF.

3.3.3b Participants in survey questionnaire.

At the time of recruitment, there were 464 international and national organisations in Lebanon registered within the Ministry of the Interior. According to the UNHCR online portal for Lebanon around 90 organisations were active in the provision of humanitarian assistance to Syrian refugees of which around 45 were active in health, food security, or nutrition (UNHCR, 2016); the precise number fluctuates from one period to the next. This study included all these agencies in addition to local organisations that were identified through the Lebanese NGO portal (daleel-madani.org). UN and government agencies were not included. 135 identified organisations registered as working in the following fields were invited to participate in the survey: 1) Food and Nutrition, 2) Relief Services, 3) Refugees, 4) Labour and Livelihood, 5) Health and Family.

3.3.3c Survey questionnaire format and content.

A survey questionnaire administered to organisations was used for data collection. The questionnaire was based on a similar questionnaire devised to survey

organisations during the 2006 war in Lebanon collecting information about distribution of infant formula and milk (Obeid, 2006). The current research adapted this questionnaire with permission to fit its research objectives and context. The questionnaire in this study included the following domains: basic information of organisation (area of operation and type of activities), IYCF policies (organisational or international), IYCF programmatic activities, and donations and distribution of infant formula and milk (Appendix 3 & 4).

Once devised, the questionnaire was tested for content validity in its English version and for face validity in both its English and Arabic versions. Content validity is the extent to which questions are relevant and appropriate to the subject matter (Polit & Beck, 2006). It ensures that the questionnaire is measuring what it is supposed to measure. In order to test content validity of the questionnaire, the latter (in English) was sent to members of the Infant Feeding in Emergency Core Group; a panel of 30 experts in IYCF-E. A request was sent by email to score the questions in the questionnaire in relation to their clarity, content, appropriateness, and relevance. A similar version of the content validity index evaluated in Barton, Wrieden, and Anderson (2011) was used. Experts were also asked to suggest modifications for questions rated low. Results from the content validity were used to modify the questionnaire. Appendix 3 includes the request for content validity and the results of the scoring. Results from the content validity were compiled and the questionnaire was modified accordingly. Modifications included re-wording questions, changing the order, and the addition of details related to the sectors (for example, nutrition as a sector was added separately, whereas it was under health).

Face validity is the extent to which the questions are interpreted as intended (Polit & Beck, 2006), i.e. whether the questions mean what they are supposed to mean. For that, the questionnaire was tested for face validity with a group of three individuals working in organisations. The latter were sent the questionnaire by email and then, asked in a face to face meeting about the questionnaire and extent to which the questionnaire was easy to complete. Probing was done to indicate the extent to which questions were understood.

3.3.3d Procedure for conducting survey questionnaire.

For each of the identified organisation, an email was sent requesting completion by either the Relief Coordinator, Programme Coordinator, Programmes Manager, or Country Representative. Recipients were advised that the respondent should be directly involved and in charge of relief activities in the organisation. The e-mail included a PIS with details about the research objectives and a confidentiality note (Appendix 4). Given that the responses were requested electronically, the sheet clarified that a completed questionnaire was considered as consent to participate under the terms of the PIS. The questionnaire also had a question confirming that participants agreed to proceed with filling the questionnaire. Three reminder e-mails were sent to encourage participation.

Survey responses were entered into Microsoft Excel. Each organisation was given an identification number (INGO# or LNGO# depending on whether they are international [INGO] or local [LNGO]) in order to ensure confidentiality. Basic descriptive analysis was conducted and open ended questions related to organisational programme

objectives were coded and entered. Objectives were coded based on the three pillars of IYCF as mentioned in the GSIYCF (WHO & UNICEF, 2003). Accordingly, programme objectives were categorised as either belonging to “IYCF promotion”, “IYCF support”, or “IYCF protection” depending on the nature of the activity described. One more category was added “health promotion” to match activities that include health awareness not specific to IYCF.

3.3.4 Focus groups with health care providers.

The fourth method of data collection consisted of focus groups with health care providers (HCPs) in PHCCs targeting refugee families. Focus group is considered one of the methods used in Case Study methodology (Yin, 2014).

3.3.4a Purpose of focus groups with health care providers.

Focus groups were used to collect information from HCPs on IYCF and IYCF-E policies, guidance, and activities. The focus groups aimed to shed light on existing barriers and opportunities related to implementation of IYCF and IYCF-E national and institutional policies and programmes from the perspective of HCPs. This method was chosen since it provides a forum for stimulus amongst different participants. Unlike individual interviews, focus groups provide the opportunity for HCPs to gain perceptions from each other (shared experience) (Wheeler & Holloway, 2010), which contribute further to investigating the Case. Although time consuming, focus groups allow different members to give input while giving an overall view on the services provided (Hennink, 2013). They also provide a picture of the interaction between participants (Duggleby, 2005). Interaction is important given that it will provide an opportunity to observe the

dynamics of the work environment. Together with the desk review and the focus groups with mothers (Section 3.3.5), focus groups with HCPs provide insight into the Case at the service provision level (Figure 3-4). Knowledge sought from HCPs fed into the perceived reality, whereas knowledge from mothers gave insight into the actual reality (Figure 3-2).

3.3.4b Participants and criteria for participating in focus groups with health care providers.

Participants included HCPs from institutions providing primary health care services. As mentioned in Chapter 2, Section 2.5 'Lebanon During the Refugee Crisis – Case Context', there are more than 220 PHCCs within the MoPH primary health system (MoPH, 2015b) including around 70 social development centres. There are also about 100 privately owned centres. Within this division, centres may also be supported by a humanitarian agency[10].

For the purpose of this study and in order to have an in-depth view on programmatic activities related to IYCF-E, focus groups were conducted with HCPs from centres that have the following criteria:

1- Part of the MoPH list of supported centres. Centres that are part of the MoPH list usually fit a list of criteria including capacity to operate as set by the Ministry.

[10] Supported means that the center would be contracted by either an international organization or a local organization to provide services to Syrian refugees at a very minimal cost. For example, instead of paying the equivalent of 5 GBP, refugees would pay only 0.5 GBP.

2- Part of the centres supported through the Syria response. These centres host the highest number of Syrian refugees.
3- Offering maternity and paediatric services in order to be relevant to the subject of the study.
4- Staff include paediatrician and nurses providing care for infants, young children, and mothers.

Two focus groups were conducted in each of the four main regions in Lebanon (Beirut/Mount Lebanon, North, Bekaa, and South). In each focus group, staff engaged in providing services were invited to participate. Each group included between four and twelve participants. After eight focus groups, saturation was reached and there was no need to include additional meetings.

3.3.4c Topic guide format and content for focus groups with health care providers.

A topic guide that focuses on collecting information about practices and programmatic activities related to breastfeeding, complementary feeding and infant nutrition was devised (see Appendix 5). The topic guide included the following topics: available IYCF programmes and services within the institution, knowledge about existing national and institutional IYCF and IYCF-E policies and their content, and challenges related to IYCF. The topic guide also included examples where participants were presented with case scenarios of mothers accessing health services to capture actual practices of HCPs.

The topic guide was translated into Arabic by the researcher herself and then back translated by an independent person in order to ensure the meaning is maintained

and not changed during translation. The focus group topic guide was administered in colloquial Arabic/Lebanese. The Arabic topic guide was tested and validated with HCPs during a training conducted by an organisation. The results of the testing were not considered as part of the findings of this study. The testing was necessary to ensure validity and reliability as well as flow and ease of administration.

3.3.4d Procedure for conducting focus groups with health care providers.

For seven of the eight focus groups, meetings were conducted in a PHCC. In the eighth, the meeting was conducted in another venue where more than one centre participated for practicality. Prior to conducting the focus groups, a request was sent to the centres requesting permission to conduct focus groups with HCPs fitting the above-mentioned criteria.

The meetings started with a welcome and introduction during which the researcher introduced herself and greeted all participants. The research objectives were explained and the purpose of the meeting. Participants were then asked to provide written consent (Appendix 5). Each question was then asked and discussion initiated. The researcher gave the opportunity for all participants to provide feedback and probed for additional details. As the discussion moved on, closing remarks were given and opportunity for questions. Focus groups were conducted in colloquial Arabic/ Lebanese and audio-recorded. The basics for conducting a focus group were maintained including making sure that the premise is satisfactory, arranging for a recorder, bringing enough copies of the participant sheets and consent forms, managing time appropriately, making sure each participant had a chance to share, and

avoiding giving personal opinions (Krueger & Casey, 2000). See Chapter 8, Section 8.2 'Role of the researcher'.

Once completed, the content of the recording was transcribed verbatim onto a document and then translated from Arabic to English as described in Section 3.3.6. During transcription and as much as feasible, the researcher attempted to identify speakers and their position within the transcript.

It is important to note that focus groups were formed of staff available at the PHCC and engaged in the provision of services for mothers and children. In most cases, staff would be formed of nurses, midwives, and the PHCC director. In other cases, other staff such as the paediatrician or technician would also participate. When the latter were part of the meeting, it was because they would hold one position with different responsibilities. For example, a lab technician would also be engaged in the vaccination of children and therefore would be part of the focus group. Although not homogenous, this variety in the participants contributed to a diversity in opinions and point of views and enriched the content of the discussion. Having a group also led to the generation of a "group perspective" (Hennink, 2013). At the same time, in some situations, the presence of the paediatrician or the PHCC director, who are considered of higher authority, would affect the extent to which other staff are articulate and felt able to voice their opinions. In this case, the interviewer made sure to engage all members of the focus group and gave them the opportunity to provide their opinion while keeping with the non-directive interviewing principles (Hennink).

Focus groups were transcribed and translated as described in Section 3.3.6. Once transcribed and translated, transcripts were then analysed using thematic analysis. See Section 3.4 'Analysis'.

3.3.5 Focus groups with mothers.

The fifth stage of data collection consisted of conducting focus groups with refugee mothers benefiting from primary health services.

3.3.5a Purpose of focus groups with mothers.

The focus groups served as a tool to collect information from the end users of services guided by existing policies and programmatic activities. This stage was important to give an end user perspective of IYCF-E programmes and policies. Focus groups provided the missing link from the central and policy level to the end user level. These shed light on existing activities and programmes that mothers benefited from. They gave a different interpretation for the reality of the Case from the context of the end user – the mother. Similar to focus groups with HCCPs, this method was chosen because it provides the opportunity for mothers to share perceptions about their experiences. Contrary to individual interviews, the focus groups create an atmosphere of sharing and communication which contribute to devising a clearer picture about the experiences related to IYCF support at the service provision level (Coenan et al., 2012).

Combined with the desk review and focus groups with HCPs, data from focus groups with mothers provided an insight into the Case at the service provision level. It also

served as a final step to compare reported activities with those actually received by the end user.

3.3.5b Participants and criteria for participating in focus groups with mothers.

Participants consisted of refugee mothers from Syria who were in receipt of primary health care services. A purposeful sampling method was used for the recruitment of mothers. The following criteria were adopted for recruitment:

1. Has one or more child less than two years of age or is a caregiver of one or more children less than two years of age.
2. Present in Lebanon for more than six months.
3. Living in the catchment area targeted by the health care centre providing services.
4. Attending one of the selected PHCC participating in the focus group with HCPs.

Two focus groups were conducted in each of the four main regions in Lebanon similar to focus groups with HCPs. In each focus group, mothers fitting the above mentioned criteria would be invited to participate through the PHCC itself. Each group included between four and twelve individuals. After eight focus groups, saturation was reached with absence of new emerging themes and there was no need to include additional meetings. In order to encourage mothers to participate, mothers attending the focus groups were provided with education about IYCF at the end of the focus group.

3.3.5c Topic guide format and content for focus group with mothers.

A topic guide for the focus group with mothers was developed focusing on collecting information related to IYCF practices and services received (Appendix 6). The topic guide included the following topics: description of assistance received related to IYCF, perceived needs and gaps in assistance related to IYCF, perceived challenges related to IYCF, aspirations for needed IYCF assistance.

Prior to using it, the guide was translated into Arabic. It was then tested and validated on ten volunteer mothers in a centre that was not participating in the study to ensure validity and reliability as well as flow and ease of administration. No major changes were made except for the order of the topics.

3.3.5d Procedure of conducting focus groups with mothers.

The focus groups were conducted at the same health centres where focus groups with HCPs were conducted. Prior to conducting the focus groups, the centre director (or another member delegated by the director) sent an invitation to mothers who satisfied the above criteria to participate in the focus group meetings. The invitation included information that an education session would be provided after the meeting which was meant to encourage mothers to attend. In some cases, mothers who happened to be at the centre and consented to participating also joined the meeting. Appendix 6 is the topic guide for the focus groups and describes the proceeding.

Because of the nature of participants, many of whom were illiterate, participants were asked to provide oral consent for participation.

The meeting started with a welcome and introduction during which the researcher introduced herself and greeted all participants. The objectives and the purpose of the

meeting were explained orally. Each question was then asked and a discussion was initiated. The researcher gave the opportunity for all participant mothers to provide feedback and probed for additional details in line with the non-directive interviewing described by Hennink (2013). As the questions were completed, closing remarks were made and an opportunity given for questions. During the meetings, the researcher ensured that the basics for conducting a focus group meeting were maintained including, arranging for a recorder, managing time appropriately, making sure each participant had a chance to participate, and avoiding giving personal opinions (Krueger & Casey, 2009). Following the focus groups, mothers had the opportunity to stay for a brief session discussing IYCF. In addition, whenever mothers highlighted an issue that needed to be addressed, those mothers would be asked to remain after the focus group had ended and the relevant actions would be taken. Mothers raising issues related to health and nutrition would be referred to a health specialist either at the centre or outside (to a NGO). Mothers with issues specific to refugees were referred to the relevant entities including UNHCR.

The content of the recording was first transcribed verbatim and then translated from Arabic to English as described in Section 3.3.6 ‘Translation of transcripts’. When possible and during transcription, the researcher attempted to add identifiers to the speakers within the transcripts that is to be able to identify who was giving the statements. This was not always possible since participants did not identify themselves every time they spoke. Once transcribed and translated, transcripts were then analysed using thematic analysis. See Section 3.4 ‘Analysis’.

3.3.6 Translation of transcripts.

This section concerns the translation of transcripts from the semi-structured interviews, focus groups with HCPs, and focus group with mothers. It provides a description of the process followed in translating transcripts stemming from all three stages of data collection.

The purpose of translation is to render the information collected readable and accessible for the research analysis and findings. It is therefore vital for translation to reflect as accurately as possible on the actual content of the transcripts. Although there are no specific guidelines for research translation into the Arabic language specifically (Khalaila, 2013), still the standard requirements of translation in research are upheld.

Following the transcription of the recordings, each transcript was translated by the researcher herself from the language originally used into English. Transcripts from semi-structured interviews used a mix of colloquial Arabic/Lebanese, English and sometimes French words. Transcripts from focus groups with HCPs and mothers were in colloquial Arabic/Lebanese. Those with HCPs were all in the Lebanese dialect; the mothers, since they were Syrians, spoke the Syrian dialect which is part of the Shami dialect and is very similar to the Lebanese (Khalaila, 2013). As described by Behling & Law (2000, p. 15) and during translation, it is important to “ensure appropriate levels of semantic and conceptual equivalence”. In this research, a common issue that was faced during translation is the challenge to relay the exact meaning of the term used in Arabic to English. Often, Arabic terms do not have a direct English equivalent. In

such cases, the researcher aimed to ensure semantic equivalence and conceptual equivalence where words were chosen to reflect the meaning of the concepts rather than actual words (Behling & Law; Birbili, 2000). The fact that the researcher herself speaks the three used languages (French in the case of the semi-structured interviews) and her intimate knowledge of the culture facilitated the process of translating the meaning rather than just the word. In order to ensure accuracy of the translation, a verification process was adopted. For each of the data collection tools, sample paragraphs from translated transcripts were randomly chosen. These were shared with an independent researcher who conducted back translation in order to ensure that the meaning was maintained (Behling & Law).

Section 3.4 Analysis

3.4.1 Analysis strategy.

In this research, and in line with the theoretical approach and methodology adopted and described in Section 3.2., the main strategy adopted was an inductive explorative approach in which themes and concepts emerged as the data were analysed. This is in line with Yin (2014), who confirms that such a strategy is convenient when results also include some quantitative data in addition to qualitative data, as in this research. Also, this strategy is consistent with the thematic analysis approach that is adopted in this research and described below as well as with the critical realism approach (Barnett-Page, 2009; Gilson, 2012).

In addition to this inductive approach, and although no one theoretical proposition was used, the analysis did rely on theoretical models in order to develop a description

of the Case (Yin, 2014, p. 129) and seek knowledge about its reality. *Two* main policy and guidance documents were used in the analysis of results:

The policy analysis approach based on Walt and Gilson's (1994) guide for policy analysis was used as a *general guiding framework*. The framework recognises that the health policy process involves four elements: 1) the context within which the policy is formulated and executed, 2) the actors involved in the policy making process, 3) the process or steps associated with the development process of policies, 4) the content. Figure 3-5 is an illustration of the framework as a model for policy analysis.

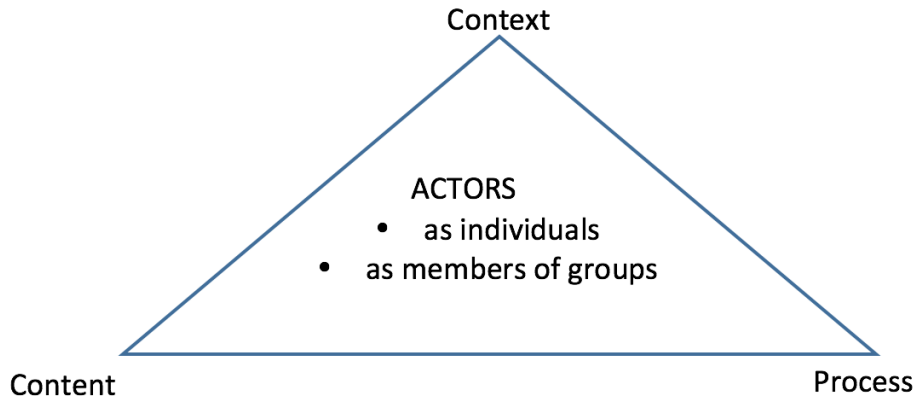


Figure 3-5 Model for policy analysis from Walt and Gilson (1994).

In the case of this research, an analysis of existing policies was conducted by examining the *context* within which such policies exist. i.e. the refugee situation, an emergency in a middle income country. Given the importance of context in a Case Study methodology, the research has provided an overview of the context, both through the desk review and the data collection. The model acknowledges that the

context influences the *process* and the *content* of policies,[11] both of which were explored in this research. The *actors* consist of the different level actors including central level (government, ministries, etc.), organisational, and service provision (HCPs and mothers). These are seen as directly influencing the course of policies. In terms of *content*, the research provides an overview of the content of the policies and it is factored that the content is influenced by the actors and the context.

A second framework used only in the *analysis* was the GSIYCF (WHO & UNICEF, 2003). As described in Chapter 4, Section 4.1 'Global IYCF, IYCF-E Policies and Guidance', the strategy categorises IYCF support into three categories: 1) promotion, 2) support, and 3) protection. The GSIYCF also recommends interventions that are in line with these three categories. In the analysis of programmes and different support services at all three levels, these categories were used to provide insight onto the existing programmes (See Section 3.3.3d for a specific example).

The Breastfeeding Gear Model (BGM) described by Pérez-Escamilla, Curry, Minhas, Taylor, and Bradley (2012) was referred to and utilised in the analysis and discussion related to the barriers and opportunities for supporting IYCF-E.

Figure 3-6 is a visual representation of how different theories and models underpinned various components of the study.

[11] For example, due to the context of the refugee situation, policies were initiated and the content was tailored to the context (e.g. in the joint statement). See Chapter 4, Section 4.2 ('IYCF and IYCF-E Policies, Guidance, and Programmes in Lebanon').

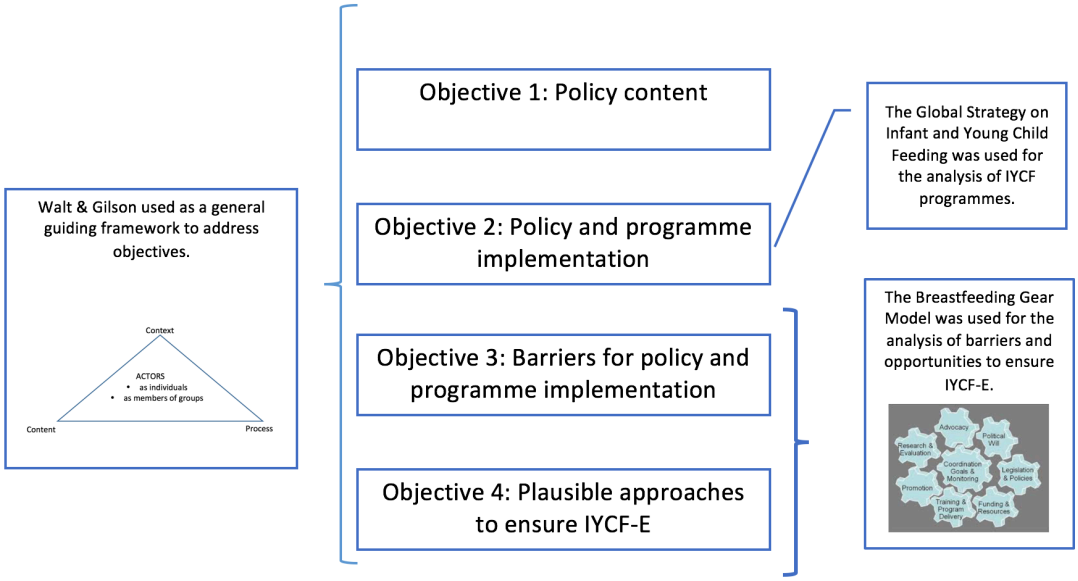


Figure 3-6 Theories and models underpinning this research

In addition to the above, the socio-ecological model is another framework used to explain mother's behaviour related to IYCF. The model is useful for understanding the multifaceted and interactive effects of personal and environmental factors determining behaviour (Center for Disease Control [CDC], 2017). The model was used in the discussion around the themes emerging from mother's focus groups on IYCF practices and needs for support.

3.4.2 Analysis methods.

As described at the beginning of this chapter, the Case Study approach used multiple sources of evidence to examine the Case. In addition, there were three embedded units of analysis where the Case was analysed at different levels (central, organisational, and institutional). First, for each source of evidence, a separate analysis was conducted, then for each unit (Baxter, 2008). Then, a convergence of

evidence was conducted to provide an overall construct of the Case and the phenomenon of interest (Yin, 2014). One of the common fails of analysis in Case Study research is focusing on each unit of analysis as a separate entity and forgetting to report on the whole Case (Baxter). Therefore, it is important to converge data in order to understand the overall Case. In converging the different sources of evidence and units of analysis, triangulation and comparison of results were conducted at the different levels of analysis. The convergence of results in this research is presented in Chapter 8.

To analyse the quantitative survey data, frequencies were calculated and tabulated. For narrative answers, coding was conducted. Specifically, for information about programme objectives, the latter were coded using the GSIYCF as described in Section 3.3.3 'Survey questionnaire' and categories devised accordingly.

For the analysis of the qualitative data from semi-structured interviews and focus groups, *thematic analysis* was adopted as described in Green and Brown (2005). The following steps were followed bearing in mind that analysis of the different sources of data occurred concurrently as advised by Yin (2014) and Baxter (2008):

Step 1: Familiarisation

Transcripts were read thoroughly to gain a general understanding of the content and develop a general impression. Notes were added to the transcripts as well as observations.

Step 2: Data coding and indexing

Once read, the transcripts were read again and this time while adding codes and indexes to each section/idea. The sections were labelled with brief descriptive codes. Appendix 7.1 includes a sample of a transcript with coding.

Step 3: Grouping and categorising by themes

Codes were grouped into categories based on the researcher's professional knowledge, the literature, and adopted theoretical frameworks which then were developed into conceptual themes and sub-themes. Appendix 7.2 includes the coding frames, themes and sub-themes generated from the different transcripts.

Step 4: Labelling

Once the themes and sub-themes were identified, a filled table of themes and sub-themes was developed whereby transcript excerpts matching to each theme were laid out in the table. In order to facilitate the task of writing the results, a summarised version of the table of themes and transcripts was developed whereby selected quotes were grouped under each theme and sub-theme in a Word document and from which quotes were further selected to be used in the presentation of results.

A further step that was conducted in the analysis of the qualitative data is a schematic mapping of the themes from each of the data sources. Building on existing theoretical frameworks, topics from the generated themes were mapped out with suggested

relations between the topics in order to provide a schematic presentation of the results and attempt to present the Case in a visual manner.

In keeping with critical realism and in the analysis of qualitative data, themes were mapped in a way to explain the causality between different identified barriers and opportunities for supporting IYCF. At the same time, plausible approaches were presented in a way to explain how different recommendations can lead to others and eventually to social change (improvement in IYCF).

Step 5: Writing of results

The final step was the writing of the results based on the generated analysis and as described above, for each unit of analysis, key findings were narrated. Then convergence of results with triangulation of findings was compiled.

3.4.3 Ensuring trustworthiness and rigour.

In order to ensure trustworthiness and rigour, several strategies were adopted including documenting the procedure of the Case Study, verifying transcripts, validating translation, and checking the coding schemes.

Central to ensuring rigour is the need to document the procedures of the Case Study including steps and procedures (Yin, 2014). This was achieved by keeping records of key thoughts and learnings, documentations used and contacts made. In addition, a detailed transcript of the methods adopted for the Case Study was provided in this chapter. This is important as it will also allow others to replicate this study (Yin, 2014).

During the process of transcription and translation, and as detailed in Section 3.3.6 'Translation of transcripts', a verification process was adopted whereby transcripts were checked and verified by independent individuals. This confirmation contributes to ensuring trustworthiness of the transcripts.

In order to ensure trustworthiness during the analysis phase, coding was verified by independent individuals. During the early stages of analysis, the researcher initiated the coding of transcripts. At the same time, coding was conducted by a peer. Codes were compared in order to verify accuracy. This exercise of "peer debriefing" (Creswell, 2013) is important to enhance the accuracy of the codes and analysis process. Codes were also double checked by supervisors. During the later stages of analysis, supervisors verified the coding schemes developed by the researcher and gave feedback.

Another strategy to ensure trustworthiness is clarifying any bias the researcher might bring to the study using reflexivity (Darawsheh, 2014). Chapter 8, Section 8.5.1 'Role of the researcher' provides a detailed account on reflexivity. Although useful, respondent validation or member checking - where study results are verified with respondents (Creswell, 2013) - was not conducted given the limited ability to reach respondents a second time.

Finally, the use of multiple methods in the Case Study approach allows the triangulation of multiple sources of data which improves the validity of the study (Yin, 2014). The triangulation of data in this research offers different perspectives of implementation of policies and activities related to IYCF-E. For example, focus groups with health care providers generate data about implementation of existing policies and key informant interviews generate data about existence of policies. In addition,

and in keeping with critical realism, the data generated is compared to reveal different aspects or realities of the phenomenon being examined.

Section 3.5 Ethical Considerations and Confidentiality

In order to ensure that research has minimal harm on participants, a number of ethical issues were taken into consideration including the principles of autonomy, confidentiality, anonymity and non-maleficence (or do no harm) (Pinto & Upshur, 2013).

3.5.1 Scientific validity and social value.

As indicated by many and emphasised by Pinto & Upshur (2013), one main ethical consideration is scientific validity and the social value of the research. The research adopted a robust methodology to ensure quality of the research. Participants were chosen using strict criteria and fair selection as described in Section 3.3 'Methods'. The nature of the research has the potential to bring added value to communities including that of mothers and infants. The study also explores possible opportunities to improve policies and programmatic activities related to IYCF in situations of crisis.

3.5.2 University research ethics.

This research study was submitted to the University of Dundee Research Ethics Committee (UREC) in order to receive approval for the different activities within the research. For practical reasons, the study was divided into two stages: stage 1 including the desk review and survey questionnaire and stage two including the remaining methods of data collection. Stage 1 presented few ethical issues given that

it included a review of the literature and documents as well as a survey questionnaire targeting organisations. Stage 2 however presented more ethical considerations given the vulnerable position of the mothers. Therefore, two applications were submitted to UREC and approved first on July 14, 2013 (UREC#13077) and February 9, 2015 (UREC#15004) respectively (Appendix 8). The former requested ensuring a risk assessment is conducted which was performed using the Health and Safety guidelines.

3.5.3 Confidentiality and anonymity.

In order to ensure confidentiality, the researcher ensured that individuals were not personally identifiable from the data. Once transcribed and translated, recordings were erased. All data were password protected on a computer which is only used by the researcher. Data were only available to the researcher and her research supervisors, who supervised the entire process. Participants were identified by codes and not by their names and therefore participant confidentiality was ensured and data was anonymised. Participants were informed that the data would only be used for the research and that information collected from participants would remain confidential. One section of the data collection involved information related to NGOs policies and practices including information related to violations of the Code and the Law 47/2008 in Lebanon. The survey of NGOs asked if at any point they participated in blanket distribution of infant formula which is considered a violation of the Code and the Law mentioned above. Throughout the study, information collected related to violations was used solely for the purpose of the study in order to report on practices and programmatic activities. In addition, and in order to increase awareness about violations and the Code, the researcher shared a copy of the Joint Statement on IYCF

issued by the MoPH and MoSA that included useful information about best practices related to IYCF in emergencies (Appendix 11).

3.5.4 Autonomy.

In order to facilitate the ethical principle of autonomy, whereby individuals are respected for being 'self-governing', a number of factors were considered. Through the execution of this research, participation was on a voluntary basis. Participants (including NGO representatives, key stakeholders, mothers, and HCPs) were provided with a full description of the research, its purpose and expectations. Participants were provided with a PIS in both English and Arabic (Appendices 2, 4, 5, and 6). The sheet included information about the research as well as clear statements explaining that participation is fully voluntary and that participants have the right to withdraw at any time if they choose to without any negative repercussions.

Participants were asked to sign a consent form informing them about the research and confirming that they understand the purpose of the study, that they are willing to participate in the study, and that they have the right to withdraw at any time. The research included exceptions for written consent. One group in the study population included mothers of infants less than two years of age who have fled from Syria and found refuge in Lebanon. A factor that was taken into consideration was that a high proportion of these mothers may be illiterate and unable to read the PIS and therefore provide informed consent. Therefore, the researcher carefully explained the study using the information approved for the participant information sheet and emphasised that mothers have the right to withdraw at any point. In cases where mothers were able to read and write, normal consent procedures were undertaken.

3.5.5 Do no harm

The avoidance of causing harm is central to the principle of non-maleficence. The current research deals with interviewing key stakeholders, HCPs as well as refugee mothers. During stakeholder interviews and focus groups with HCPs, participants were treated fairly and with respect. Participants were not coerced or led to say anything. The researcher did not agree nor disagree with what participants in the interview or focus group were saying, but facilitated the expression of their views. Participants were given full freedom to express their opinions and the researcher was not pushy, aggressive or condescending, or used any behaviour that might be interpreted as bullying.

Particular care was taken when interviewing mothers in focus groups given their vulnerable position as refugees. Some of the mothers have had to endure hardship and trauma and some of the information that is collected may bring back memories that may affect mothers' emotional and mental health. According to Hugman, Pittaway, and Bartolomei (2011), studies targeting refugees need to take extra caution in order to minimise harm and that the regular 'do no harm' principle is insufficient and further participatory approaches need to be considered. They emphasised that although the 'do-no-harm' could be well meant, it could still put refugees at risk by the process of the research if not well addressed. Drawing on that, the researcher has had previous work experience with refugees and ensured that training principles were applied e.g. provided time for mothers to answer at their own pace, using non-judgemental comments. As per Hugman et al. (2011), creating a relationship with mothers is essential to ensure comfort and frank participation. Mothers were given

the opportunity to withdraw or not answer if they chose to. This was also articulated in the consent form where it was indicated that “there will be no penalty” and that they “will not lose any benefits to which [they] are otherwise entitled” (Appendix 6). The focus groups were conducted at primary health centres where mothers were provided with a comfortable room to sit in with their children. Approval was taken from the primary health centres to conduct the focus groups at the premise.

Mackenzie, McDowell, and Pittaway (2007) also highlighted some of the challenges of conducting research in refugee settings and emphasised the importance of recognising the need to conduct research that brings about reciprocal benefits. In this research, mothers were given the opportunity to attend an educational session at the end of the focus group. In addition, whenever a mother highlighted a problem that needed to be addressed, that issue would not be ignored and relevant actions were taken. For example, if a mother recounted difficulties with exclusive breastfeeding, she would be referred to a lactation specialist.

The following chapters (4, 5, 6, 7, and 8) are a presentation of the findings and relevant discussions of the results. Chapter 4 is a document review of existing policies and guidance and national programmes, while Chapters 5, 6, and 7 present findings and discussions for the central, organisational, and service provision levels respectively. Chapter 8 includes the convergence of findings and presentation of the Case.

Chapter 4 IYCF-E POLICIES AND PROGRAMMATIC GUIDANCE: FINDINGS FROM THE DOCUMENT REVIEW

This chapter presents findings from the document review conducted on existing IYCF and IYCF-E policies and guidance at the global and national level as well as documented national IYCF programmes. It is important as it documents existing knowledge about the reality of the Case.

Section 4.1 Global IYCF, IYCF-E Policies and Guidance

While it has been recognised as vital, it is not always easy to ensure adherence to recommended IYCF practices especially during emergencies. During such circumstances, breastfeeding may be disrupted or stopped because mothers are ill, traumatised or separated from their babies (Jakobsen et al., 2003). Emergencies most often happen in countries where there are already poor infrastructure and crises can lead to further deterioration, still, in countries where there is a high rate of artificially fed infants, it may also be difficult to ensure safe artificial feeding (Gribble & Berry, 2011). Other factors that can undermine feeding practices during emergencies include inappropriate interventions that consist of the blanket distribution of infant formula, milk or milk products (Talley & Boyd, 2013).

Lack of IYCF-E policies or poor implementation of existing policies has proven to be a constraint to effective support for IYCF (ENN, 2007b). Recognition of this situation by the international community has led to a number of strategies, frameworks, and policy

guidance to be developed which set out responsibilities related to IYCF-E (including those that were developed for non-emergency settings).

The focus of this section is on existing IYCF policies and guidance. For clarity and according to the WHO, a health *policy* is referred to as the written document that includes rules and guidelines about a certain health aspect aimed at strengthening the health system. A health policy includes guidelines and plans developed to reach a specific health care goal within a society. In general, a health policy would include an aim for the future but also priorities on the shorter term. It also builds consensus and informs people (WHO, 2016f). Whereas a health policy covers health objectives, a nutrition policy is focused on improving the health of a society through regulations related to healthy nutrition habits (FAO, 2016).

Guidance refers to the written set of advice, information, or direction that provide instructions. Policy or programmatic guidance refers to a document that provide official guidelines for implementing a policy or a programme (The American Heritage Dictionary, 2016). A *Strategy* is also considered to include guidance and can be a "guide for action" that identifies effective interventions to reach a set of goals or objectives (WHO & UNICEF, 2003).

The following is a review of documentation related to policies and guidance on IYCF in normal situations and during emergencies. Policies and guidance in normal situations are listed first, then those that are specific to emergencies followed by existing guidance related to IYCF programming. In addition, the section includes relevant

resolutions and position statements issued by international organisations relevant to IYCF and IYCF-E. As described in Chapter 3, Section 3.3 'Methods', inclusion criteria were set for the selection of documents for review.

4.1.1 Global IYCF and IYCF-E policies and guidance.

4.1.1a The International Code of Marketing of Breast Milk Substitutes and subsequent relevant World Health Assembly resolutions (the Code) – 1981.

One of the first policy documents developed to protect breastfeeding is the International Code of Marketing of Breast Milk Substitutes (the Code). It was first adopted by the World Health Assembly (WHA) in resolution 34.22 in 1981. Later, subsequent relevant WHA Resolutions were also adopted. These resolutions and the original one are collectively referred to as "the Code" (WHO, 1981).

The Code was devised to protect mothers and caregivers of infants and young children from the marketing and commercial influences on infant feeding choices. The Code regulates the marketing and sets out responsibilities of baby food industries, HCPs, governments, and organisations in terms of marketing of "Breast Milk Substitutes"[12] , feeding bottles and teats. The Code does not forbid the use of infant formula or bottles but controls how these are produced, packaged, promoted, and provided. In WHA 34.22, all Member States were called upon to support the implementation of the Code. The main target of the Code is formula companies who must comply with the Code independently of whether there are any legislative measures taken within a

[12] Breast Milk Substitutes (BMS) are defined by the Code as any food being marketed or otherwise represented as a partial or total replacement of breast milk, whether or not suitable for that purpose. In practice, this means any product promoted for use in an infant under six months of age or as a replacement for breast milk from six months of age to 2 years or beyond (WHO, 1981).

country to implement the Code (Article 11.3 of the Code).

The IBFAN publishes regular reports on breaches to the international code including those in emergency affected countries (IBFAN, 2016). In 2014, WHO and UNICEF developed a Network for Global Monitoring and Support for Implementation of the Code (NetCode). The Network merges efforts of civil society organisations, academia and selected countries to detect, investigate, and act on detected violations (WHO & UNICEF, 2017). Guidance has been published on how to abide by the Code especially in relation to HCPs within the Baby-Friendly Hospital Initiative (UNICEF-UK, 2015). Frequently asked questions about the Code have been answered through guidance documents that are regularly updated (WHO, 2017c).

All provisions of the Code apply in emergencies, however, some parts are particular to emergencies such as WHA 47.5 (1994). Code implementation in countries that are prone to emergencies and setting legislative actions are also essential prerequisites for emergency preparedness since in emergencies Code violation has been frequently reported (IBFAN-ICDC, 2009).

4.1.1b Innocenti Declaration on Infant and Young Child Feeding.

The Innocenti Declaration was produced in 1990 calling for action and efforts for the protection, promotion, and support of breastfeeding (Innocenti Declaration, 1990). Fifteen years after, following the GSIYCF, and in an attempt to meet the MDGs by 2015, the Innocenti Declaration on Infant and Young Child Feeding was declared in 2005 (Innocenti Declaration, 2005). The Declaration calls for government and donor

commitment to increase resources for IYCF as a key child survival strategy and to implement the GSIYCF.

The Declaration also tackles emergency situations where it states: “protect breastfeeding in emergencies, including by supporting uninterrupted breastfeeding and appropriate complementary feeding, and avoiding general distribution of breast milk substitutes”.

4.1.1c The Baby-Friendly Hospital Initiative (1991).

The Baby-Friendly Hospital Initiative (BFHI) is an international programme that was developed by WHO and UNICEF in 1991 following the adoption of the Innocenti Declaration in 1990 (WHO & UNICEF, 1991). It is a global effort for improving the role of maternity wards to protect, promote, and support breastfeeding. The initiative promotes Ten Steps to Successful Breastfeed to be adopted as the standard for care for all new-borns. The Ten Steps encompass health facility issues, including having a policy on breastfeeding, staff training, rooming in, early initiation and other mother/baby care standards such as avoiding artificial teats, as well as outreach into the community. Having hospitals applying the Ten Steps is considered a key IYCF-E preparedness measure.

4.1.1d WHO/UNICEF Global Strategy on Infant and Young Child Feeding.

One of the main and first documents developed to emphasise the importance of improving IYCF practices is the Global Strategy on Infant and Young Child Feeding

(GSIYCF) (WHO & UNICEF, 2003). The strategy was developed and adopted by the WHA in 2002. It followed the BFHI (1991), the Code (1981) and Innocenti Declaration on the protection, promotion, and support of breastfeeding (1990). The strategy starts out with an emphasis on the need for "comprehensive national policies" on IYCF, including those on supporting IYCF in "exceptionally difficult circumstances". It emphasises the importance of ensuring all health services protect, promote, and support exclusive breastfeeding and timely and adequate complementary feeding with continued breastfeeding. The strategy presents the challenges on improving IYCF practices and thus identifies types of interventions that have a proven positive impact. The strategy divides the main "high-priority actions" under three actions: the protection, promotion, and support of IYCF. Support is also divided through the health care and in the community. The strategy has a specific section that elaborates on support for feeding infants and young children in exceptionally difficult circumstances, i.e. emergencies. It recommends providing appropriate feeding support for infants and young children in emergencies and the development of knowledge and skills base of health workers working with carers and children. It also sets out the types of interventions needed by stakeholders to achieve the objectives of different actors. The GSIYCF was later complemented by a Planning Guide for the national implementation of the strategy (WHO & UNICEF, 2007).

4.1.1e The Rome Declaration on Nutrition.

In 1992, and during the first International Conference on Nutrition (ICN), the World Declaration and Plan of Action for Nutrition included a main priority theme which was "promoting breastfeeding" (Food and Agriculture Organisation [FAO] & WHO, 1992).

In 2014, the Second International Conference on Nutrition (ICN2) by WHO and FAO reaffirmed that “nutrition policies should promote a diversified, balanced and healthy diet at all stages of life. In particular, special attention should be given to the first 1000 days, …… by promoting and supporting adequate care and feeding practices, including exclusive breastfeeding during the first six months, and continued breastfeeding until two years of age and beyond with appropriate complementary feeding” (FAO & WHO, 2014). The INC2 outcome document also included a commitment to “develop policies, programmes and initiatives ….. in particular … promoting, protecting and supporting exclusive breastfeeding…..” as per the WHO recommendations.

4.1.1f Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition.

In 2014, and in an attempt to achieve six global targets including breastfeeding by 2025, an action plan was developed that includes priority action to be implemented by Member States and international partners. Actions revolve around encouraging the implementation and the monitoring of food and nutrition policies and providing human and financial resources for the implementation of nutrition interventions. The plan was previously included under WHA 65.6 published in 2012.

4.1.1g Rights of Women and Children.

In addition to the above, a number of international conventions also confirm the importance of IYCF either directly or indirectly. The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1996) (WHO, n.d.), the Convention on

the Elimination of all Forms of Discrimination Against Women (1979) (Un.org, 2015) and the Convention of the Rights of the Child (1989) (Ohchr.org, 2015) all focus on the importance of promoting and protecting the nutritional well-being of women and children.

Article 24 of the Convention of the Rights of the Child in 1989 mention the right of the child to the "enjoyment of the highest attainable standards of health". It also specifies that parents have the right to full and unbiased access to information and education and are supported in the use of basic knowledge of child health and nutrition, including the advantages of breastfeeding, hygiene, and environmental sanitation (Ohchr.org, 2015). It is therefore considered a right for every infant, child and mother to breastfeed and receive the needed nutrition.

In addition to policies and guidance on IYCF in general, a number of international policy documents were set in place to ensure adherence to recommended IYCF practices during emergency situations. The main documents include the WHO Guiding Principles on IYCF-E and the OG-IYCF-E. In addition, resolutions have been put in place to encourage countries to make provisions for IYCF in emergencies.

4.1.1h WHO Guiding Principles on Infant and Young Child Feeding in Emergencies.

Ten Guiding Principles were set out in 2004 by WHO to contribute to the prevention of child morbidity and mortality amongst children in emergencies (WHO, 2004). The Principles include breastfeeding, use of BMS, complementary feeding, food aid, food security, caring for caregivers, assessment and evaluation. The Principles emphasise

that recommended IYCF practices are the same as those that apply in any other situation. The aim of the Principles is also to inform key stakeholders about the main interventions required to protect and promote IYCF.

4.1.1i The Operational Guidance on Infant and Young Child Feeding in Emergencies – A Guide for Programme Managers.

The latest guidance on IYCF-E is the Operational Guidance on Infant and Young Child Feeding in Emergencies (OG-IYCF-E) (IFE Core Group, 2007). The OG-IYCF-E was developed through efforts from an interagency collaboration called the "Infant Feeding in Emergencies Core Group" which was established to assist with emergency response specifically in relation to IYCF-E. The OG-IYCF-E is meant to be a "practical reflection" of available policies and strategies. It is a compilation of key policy guidance put into a practical guide including the WHO Guiding Principles, GSIYCF, and the Code. It is based on these policies and provides a practical compilation.

The OG-IYCF-E provides non-technical guidance and targets not only HCPs and nutritionists but also emergency and relief programme managers. It builds on the fact that IYCF practices are not only influenced by care providers but also by general relief actors and even logisticians who may be involved in frontline support and distribution of assistance. The OG-IYCF-E also targets those designing food rations, communication officers as well as the staff involved in programming. The OG-IYCF-E have been recognised as assisting with the practical application of the WHO Guiding Principles on IYCF-E and containing updates on IYCF-E practices (ENN, 2007a; 2007b; 2011). The OG-IYCF-E extends to non-emergency situations, mainly emergency preparedness and

resilience. Authors in the OG-IYCF-E specify that the document is a “living” document that is updated based on experience, evidence and policies. The OG-IYCF-E has had a significant impact which include the development of training material such as the Harmonized Training Package (ENN & NutritionWorks, 2014), the Sphere IYCF Standards (Section 4.1.1j) and was also endorsed in WHA resolution (63.23) in 2010. In 2016, the Infant Feeding in Emergency Core Group set out to revise the OG-IYCF-E and a newer version came out in October 2017.

4.1.1j The Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response.

The Sphere Handbook Project aims to establish standards by which the humanitarian community responds to disasters and emergencies (Sphereproject.org, 2016). In 2011 a new version was published where sections related to IYCF-E built on the OG-IYCF-E. As a general document, the Sphere Handbook Project defines and ensures the upholding of standards by which the humanitarian community responds to the needs of individuals affected by crisis and disasters. The section in the handbook relating to nutrition and IYCF emphasises again the guidance set out in the OG-IYCF-E.

The first standard that the document lists is “policy guidance and coordination”. As guidance notes, the document emphasises the importance of having policy documents to guide emergency programmes in IYCF. The document also references the WHA Resolution 63.23 (2010) which highlights the need to ensure that emergency preparedness plans and emergency response plans follow the OG-IYCF-E.

In emergency preparedness, the document lists i) policy development, ii) orientation

and training on IYCF-E, and iii) identification of Code-compliant sources of BMS as well as complementary food. A new version of the Handbook is due to be published in 2018.

4.1.2 Interim guidance.

Other than established and endorsed guidance, a number of interim guidance have been developed responding to special situations such as the Ebola epidemic and the refugee transit situation in Europe. The most recent interim guidance includes the "WHO/UNICEF/WFP Interim guideline: Nutritional Care of Children and Adults with Ebola Virus Disease in Treatment Centres" (WHO & UNICEF, 2014b), the "Interim Operational Considerations for the feeding support of Infants and Young Children under 2 years of age in refugee and migrant transit settings in Europe" (UNICEF et al., 2015) and the "Breastfeeding in the context of Zika virus - Interim guidance" (WHO, 2016a).

4.1.3 Organisational policies.

In addition to global and international guidance on IYCF-E and as recommended by the OG-IYCF-E, organisations have set out to develop their own policies on IYCF-E (Save the Children, 2016 and ennonline.net., 2017). For example, UNCHR has a policy on the acceptance, distribution and use of milk products in refugee settings that was issued in 2006 (UNHCR, 2016a). World Vision has an IYCF-E policy that was published in 2011 (World Vision International, 2017). The International Lactation Consultant Association (ILCA) published a position paper on IYCF-E in 2014 emphasising that supporting the health and wellbeing of affected populations in emergencies should be a priority and

that the support should include provisions for IYCF (Carothers & Gribble, 2014). Action Against Hunger (ACF) (Actionagainsthunger.org, 2017) and Save the Children also published a similar paper (Google Docs, 2017).

In addition to policies, programming guidance to support IYCF-E have been set by different organisations including the WHO and UNICEF. A compilation of guides was done by Save the Children within the IYCF-E toolkit (Save the Children, 2016). Most if not all of these programming guides refer to the OG-IYCF-E (IFE Core Group, 2007). IYCF-E programming guidance revolve around providing support for breastfed and non-breastfed infants during emergencies, to ensure appropriate IYCF, and contribute to decreased mortality and malnutrition. The UNICEF programming guide on IYCF (UNICEF, 2012) highlights the following priority actions:

- Emergency preparedness and planning,
- Protecting, restoring and supporting breastfeeding,
- Preventing and handling donations of BMS and powdered milks,
- Ensuring appropriate feeding for children with no possibility to be breastfed,
- Ensuring availability and use of age appropriate complementary foods and supplements, and
- Ensuring the integration of IYCF counselling with emergency programmes for the management of SAM.

Other guidance exists within training guides by UNICEF (Nutritionworks.cornell.edu, 2014) and the ENN (ENN, 2007; 2011). Appendix 9 includes a listing of available IYCF-E policies and other resources.

A main emphasis within the IYCF-E programming guides is the integration of IYCF activities within existing interventions. The IYCF friendly framework recently published highlights the importance of integrating IYCF-E within the different interventions such as WASH, Shelter, education etc. (Save the Children & UNHCR, 2015). This is also included in the GNC strategy and other guidance for programming.

4.1.4 IYCF-E preparedness.

In order to support adherence to recommended IYCF practices during emergencies, existing guidance emphasise the need to ensure that clear preparedness plans are put in place including provisions for supporting the non-breastfed children (Gribble & Berry, 2011). The GNC strategy also highlights the importance of having preparedness plans in relation to IYCF-E in order to ensure that IYCF is prioritised and supported during emergencies (GNC, 2014). The WBTI indicator on IYCF-E includes several markers including the presence of an emergency preparedness plan to undertake activities that ensure exclusive breastfeeding and appropriate complementary feeding and to minimise the risk of artificial feeding and available resources to implement that plan. The ILCA position statement highlights the importance of conducting training in emergency preparedness with local emergency organisations and specialised training in IYCF-E as a preparedness measure (Carothers & Gribble, 2014).

4.1.5 Gaps in IYCF-E policies and programme support.

Despite the presence of international and global policies related to IYCF and IYCF-E, it is important to ensure these are implemented through proper monitoring. The

following is a review of existing documentation and identified gaps related the implementation of existing IYCF and IYCF-e policies and guidance.

The WBTI was initiated to document the state of policy and programmes on IYCF (WBTI, 2016). Country level reports are published in addition to global reports. WBTI reports point out to specific gaps in policy and programmes in several countries and recommend the need for further advocacy for IYCF and implementation of the GSIYCF (Gupta et al., 2012). The most recent report on the national implementation of the Code was published by WHO, UNICEF and IBFAN in 2016 (WHO & UNICEF, 2016). The survey reported an increase in the number of countries that had some form of legal measure to implement the code from 103 in 2011 to 135 in 2016. However, the provisions varied amongst countries. For example, of those 135 countries, only one third cover products for use for children older than one year of age. The report also includes findings on enforcement mechanisms where very few (less than 32 countries) countries had functional mechanisms and only six countries had budgets for enforcement. In fact, it is important to note that actions including sanctions in events of violations are not applied unless a legal framework exists. For that, it is important to ensure national legislations are established.

WHO also has a guide for assessing national policies (WHO, 2003) and together with the WBTI, seek to inform on the situation of policy and programme implementation. Recently, a report on the national implementation of the BFHI was published by WHO (WHO, 2017b). The report provided an analysis of the status of BFHI in 117 countries and indicated that only 43% of the countries reported implementation of “some of the

Ten Steps" and that the poor implementation of the Code was considered as a major hurdle for the implementation of the BFHI.

Challenges for the implementation of IYCF policies have been documented in some cases and barriers have been identified including shortage in capacity, the unavailability of clear policy guidance and lack of monitoring (Mkontwana et al., 2013). The WHO/UNICEF implementation of the Code report highlighted significant challenges for the implementation of the Code including 1) lack of political will, 2) the interference of product manufacturers. 3) lack of capacity, 4) absence of coordination and 5) limited resources for legislation, monitoring and enforcement (WHO &UNICEF, 2016). Forsyth (2013; 2010) indicated that non-compliance to IYCF policies (mainly the Code) is not only confined to the infant formula industry, (considered a main culprit) (Brady, 2012), but may also arise due to systemic gaps at different levels of implementation and monitoring. Non-compliance has been reported at different levels including government and primary health. Forsyth emphasises that there is a need to ensure that all stakeholders including policy makers are responsible for the implementation of the WHO code and other IYCF policies. He highlighted the critical role of health services and the need for systems to be in place to ensure that contact between the formula industry and health care workers does not undermine breastfeeding.

In terms of policies related to emergencies, the literature is scarce, however, it is evident that implementation may become even more challenging. Gupta et al. (2012) evaluated provisions related to IYCF-E and revealed that one of the weakest indicators

evaluated by the WBTI and the least achieved was the one related to emergencies. They highlighted that emergency preparedness plans are absent from many national plans especially developed countries. For example, recently it was reported that IYCF-E provisions are almost absent in the UK (Breastfeeding trends UK, 2017). Similarly, Hargest-Slade and Gribble (2015) highlighted the need for IYCF-E provisions even in high income countries.

Gaps exist not only in policies but also in support programmes during emergencies despite the presence of relevant guidance. Interventions for the support, promotion and protection of IYCF have been implemented globally both during emergencies and in normal situations however, evidence about the efficiency and effectiveness of interventions is still lacking. Save the Children UK (2012) conducted a review of gaps and challenges related to IYCF-E programming through a consultative process with implementing agencies around the world. The main barriers and challenges identified include a lack of funding for IYCF-E programming and the lack of human resources and/or expertise in IYCF-E. The report also highlighted weak government policies and involvement as a challenge for the implementation of IYCF-E programmes. Despite the presence of programming guidance as listed above, the evidence base related to what works in nutrition in emergency programming is still scarce (Webb et al., 2014). There is a gap in a practical step-by-step guidance on IYCF-E programming (Save the Children UK, 2012) but also evidence about what works mainly because of the difficulty of conducting research during emergencies (Webb et al.).

There are a few empirical research studies on IYCF-E interventions. In fact, Prudhon et al. (2016) have highlighted gaps in IYCF-E research particularly in programming. Ayoya et al. (2013) documented lessons learned in protecting and improving breastfeeding practices in Haiti and found that there is a need for better monitoring. They describe a “baby tents” programme where tents are established to provide a safe place for mothers to breastfeed and non-breastfed infants to receive ready-to-use infant formula based on guidance. They report on the value of rapid programme-scale up and the large coordinated response as key in the success of the programme. Talley & Boyd (2013) highlighted the challenges also in Haiti in IYCF programming. They evaluated the provision of artificial feeding support in the form of ready to use infant formula and found challenges including the lack of consistency in targeting non-breastfed infants. Bassil et al. (2016) conducted an evaluation of an IYCF-E programme in Jordan through a Case Study approach and noted the successes of a comprehensive intervention that includes one-on-one counselling and support for mothers. The evaluation however also highlighted the importance of integration of activities within existing health services as well as actions to ensure sustainability, an aspect that is seldom addressed during emergencies. UNICEF (2013a) conducted a review of infant feeding programmes in six countries and came up with lessons learned for IYCF programming. The main factors identified included international leadership, enabling environment, coordination, community outreach, and ensuring the provision of “interpersonal counselling” for improved feeding. The report also found that outcomes were better when there are champions that are dedicated to breastfeeding and good coordination. Other examples of operational research include the Alive and thrive Initiative (Hajeebhoy et al., 2013) and the scaling up of IYCF (Pérez-Escamilla et

al., 2012). Although not specific to emergencies, however these highlight important factors for the scale up of IYCF interventions. See Chapter 8, Section 8.4 'Plausible Approaches to Optimise IYCF-E'.

Section 4.2 IYCF and IYCF-E Policies, Guidance, and Programmes in Lebanon

As indicated above, global policies are best implemented when national legal actions are taken. Given the existing poor feeding practices in Lebanon and in view of the vulnerable situations that Lebanon undergoes, it is important to review existing provisions for IYCF and IYCF-E in Lebanon. The current section is an overview of existing policies, guidance including strategic documents, and programmatic activities related to IYCF and IYCF-E in Lebanon. The section also serves to examine the extent to which existing policies and guidance are in line with international guidance and whether these have been reported to be implemented addressing part of the first objective in this study (Figure 3-4). As described in Chapter 3, Section 3.3 'Methods', inclusion criteria were set for the selection of documents for review.

4.2.1 Policies and guidance on infant and young child feeding in emergencies in Lebanon.

Lebanon has signed all three conventions focusing on the importance of promoting and protecting the nutritional well-being of women and children; the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of all Forms of Discrimination Against Women.

In 1983 a decree was issued on the marketing of BMS, less than two years after the launching of the Code. However, Legislative Decree No. 1983/110, 'Marketing of Breast Milk Substitutes' (issued in 1983), did not come with a clear operational plan, no activities were conducted until the early 90s with UNICEF and the MoPH initiating activities under National Committee for the Protection, Promotion, and Support of Breastfeeding (El Zein, 2012).

In 1993, and following the conduct of two national situation analyses on IYCF in Lebanon, two public announcements (number 65 and 66) were issued by the MoPH. The first announcement prohibited the distribution of the samples of BMS and the hanging of posters or pictures or ads by formula companies in any governmental institution. The second announcement related to committing governmental hospitals and governmental institutions to the Ten Steps of the BFHI (El Zein, 2012). In 2002, the Lebanese government endorsed the GSIYCF.

The more recent and only main official local document that includes guidance related to IYCF in Lebanon is Law 47 issued in 2008 (Republic of Lebanon [RoL], 2008). The Law entitled "Organizing the Marketing of Infant and Young Child Feeding Products and Tools" was based on the Code (El Zein, 2012). It aims at ensuring safe provision of healthy nutrition for infants and young children and emphasises the three pillars of optimal IYCF: to protect, promote, and support breastfeeding. The Law also stresses the importance of ensuring safe use of complementary food and products. As it is built on the Code, the Law focuses on regulating methods of marketing of products targeting infants and young children. Law 47/2008 reconfirms WHO's

recommendations on appropriate infant and young child nutrition including encouraging exclusive breastfeeding during the first six months of age, then introducing adequate complementary food as of the age of six months; and ensuring breastfeeding is continued for no less than two years of age. A copy of the Law is found in Appendix 10. The main differences between the Lebanese Law 47/2008 and the Code include the types of products that the Law regulates and age group that it includes. The Lebanese Law (contrary to the Code) covers in addition to BMS, baby food products. The Lebanese Law considers that young infants are children up to the age of three years whereas the Code considers young infants to be no more than two years of age. Law 47/2008 is a modification of the earlier Legislative Decree No. 1983/110, 'Marketing of Breast Milk Substitutes' (issued in 1983), which was a simplified and less strict version of the international Code. Law 47/2008 also includes the announcement that a Committee will be formed to oversee the implementation of the Law. The "National Committee for the promotion and protection of breastfeeding" serves as an advisory committee to the Minister to advise on design of a national strategy on IYCF. The committee also has supervisory roles on other local subcommittees whose roles are to oversee the implementation of the Law in different regions. The Law does not include a special section about emergencies nor does it emphasise the importance of applying the Law in emergency situations. However, it does mention that it is enforced as soon as it is published in the official gazette which was in December of 2008. Although Law 47/2008 was issued in 2008, it was not launched until 2011 in an official launching event hosted by the MoPH Director General (DG) (Akik, 2014).

Following the launching of Law 47/2008, the DG issued a decision to establish the National Committee for Ensuring Proper Infant and Young Child Feeding (El Zein, 2012). The committee was established in April of 2012 and included members from different organisations including UN agencies and syndicates. The work of the committee was to ensure adequate IYCF practices in Lebanon. An action plan that includes activities on IYCF was developed and sub-committees were formed each of which focuses on a main topic including, BFHI, maternity protection, mother support, and awareness. One main sub-committee is the IYCF-E sub-committee which works on planning and implementing activities focusing on IYCF-E.

Other documents that were published relating to IYCF-E are two Joint Statements on Infant and Young Child Feeding in Emergencies issued in 2006 and 2012. The first was issued following the 2006 war by the international humanitarian community, MoPH and MoSA emphasising the importance of abiding by the Code (MoSA et al., 2006). Later, in 2012 and following the beginning of the crisis and the influx of Syrian refugees into Lebanon, the second joint statement was issued, this time in coordination with the National Committee for Ensuring Proper Infant and Young Child Feeding as part of the MoPH (MoPH et al., 2012). The Statement was endorsed by a number of local and international organisations, UN agencies as well as MoSA (Appendix 11). The statement was considered a policy document serving as an addendum to the Lebanese Law, however, it was not published in the official gazette to render it official. The joint statement was based on a standard template for joint statements on IYCF in emergencies (ennonline.org, 2014b) and included provisions in line with the OG-IYCF-E.

4.2.2 Existing strategic documents and plans in Lebanon.

In addition to policy documents, a review of existing strategic and planning documents that include provisions for IYCF was conducted. The main strategic documents published by the government are listed in Appendix 12. In addition, the crisis response plan has included strategic documents developed by UN agencies and NGOs at the beginning of the crisis and later on with the engagement of the government (UNHCR, 2017). Starting 2015, strategic plans were published jointly by UN agencies and the Lebanese government (GoL & UNCHR, 2016; 2017). None of the identified strategic documents are specific to nutrition or IYCF indicating the absence of an IYCF strategy. All those identified are either health strategies, emergency preparedness plans, or crisis response plans.

4.2.2a National strategic documents.

Prior to the current crisis, the MoPH had published a *National Health Strategic Plan* (MoPH, 2007). The strategy highlighted two goals; improving the capacity of the health system and improving the equity of the system amongst different population groups. The strategy includes other objectives including improving overall quality of health service delivery and strengthening preventive programmes. Financial sustainability and efficiency were key principles in the strategy indicating challenges in finance. The strategy includes a two-phase plan that revolves around supporting primary health care. In terms of IYCF and within the different specific objectives and activities, the strategy includes an activity on the reactivation of the BFHI as well as one key performance indicator related to initiation of breastfeeding within Baby-

Friendly hospitals. The objectives also include activities related to adopting a basic health package and training on safe motherhood, however there are no specific mentioning of IYCF services or priorities to support IYCF at the primary health level. In terms of emergency preparedness and provisions for IYCF-E, the document only highlights the importance of preparedness and the value of supporting health services as a preparedness measure, but does not include wording about IYCF-E.

From the start of the crisis, no other national strategic document was published until 2015 when a "Health Response Strategy" (HRS) was published by the MoPH in response to the crisis (MoPH, 2015c) and then a joint (GoL and UN) "Lebanon Crisis Response Plan 2015-2016" (LCRP 15-16) was also launched (GoL & UN, 2015).
Both documents emphasise the need to support primary, secondary, and tertiary healthcare for Syrian refugees as well as the host community. The strategies also highlight the need to strengthen national health systems. Neither breastfeeding nor complementary feeding are mentioned in the HRS or LCRP 15-16. However, the most recent LCRP 2017-2020 does include IYCF as part of the health sector intervention. The plan also highlights that Lebanon does not have an IYCF strategy to guide activities (GoL & UNHCR, 2017).

In almost all strategic documents, priorities related to strengthening the health system exist. Health priorities include immunisation and control of communicable diseases as well as the prevention of NCDs. Mental health is also highlighted in a number of documents. It is worth noting that on July 12, 2017, the MoPH launched a new

National Health Strategy, however, the document was not available for examination at the time of writing.

4.2.2b Emergency preparedness.

In 2009, the UNDP with the Office of the Prime Minister and other organisations launched the "Strengthening Disaster Risk Management Capacities in Lebanon" project, which aims to assist the Government of Lebanon to develop its disaster management and risk reduction strategy (United Nations Development Programme [UNDP], 2010). One of the main results of this project was the development and implementation of a national Disaster Risk Reduction (DRR) strategy. In 2015, an evaluation of the outcomes of this project were conducted which revealed that the project had contributed to improved coordination for disaster risk reduction. One main outcome of the project was the establishment of a National Coordination Committee (NCC) by the Prime Minister. The development of a National Disaster Response Plan was found to be useful, however, this plan was not accessible to be examined. Reviewed project documents did not mention pregnant and lactating women, nor infants.

Another strategy document for emergency preparedness is the MoPH-issued Emergency Health Contingency Plan (MoPH, 2015d). The plan takes into consideration scenarios where the country would be exposed to emergencies and therefore details plans for response. The document does not include any provisions for breastfeeding, infant feeding, nor complementary feeding. Lactating women are mentioned as part of a section highlighting the need for coordination to support reproductive needs. The

annexes of the document include the Integrated Management of Childhood Illnesses (IMCI) which have a section on IYCF, however it is not indicated whether the IMCI is tailored to Lebanon or not and the annex is not included in the document.

4.2.3 IYCF and IYCF-E programmatic activities in Lebanon.

Documentation on IYCF activities is mostly in the form of summary reports or articles in organisational newsletters or bulletins which makes it difficult to have access to programme details. The main resources used to retrieve information on IYCF programmes include documentation conducted by MoPH staff and key actors on IYCF-E including minutes of meetings and summary reports from INGOs and UN agencies.

Since 2012, several activities were reported to be implemented as part of the committee established as a result of Law 47/2008. Activities include trainings for hospitals on BFHI, execution of media campaigns, and a number of IYCF-E activities which were implemented within the Syria Refugee Response. Section 2.6.1, paragraph 3, mentions a few documentations related to IYCF-E activities in Lebanon.

Some of the documented IYCF-E activities includes:

1. Capacity building and training for HCPs on IYCF
2. Capacity building and training for NGO workers on the Code and Law 47/2008
3. Provision of counselling and awareness for mothers in difficult situations including Syrian refugees

4. Development of educational material on IYCF targeting HCPs and families.

Most of the documented IYCF-E activities are reported to be implemented in the context of the Syrian refugee crisis in Lebanon and have been funded by UNHCR or UNICEF and implemented through INGOs (UNHCR, 2017).

Chapter 5 IYCF-E POLICIES AND PROGRAMMATIC ACTIVITIES: FINDINGS AT THE CENTRAL LEVEL

This chapter presents results from the semi-structured interviews with key stakeholders and gives insight into the Case at the central level. Section 5.1 is a presentation of the findings and Section 5.2 is a discussion of the key findings at the central level.

Section 5.1 Results – IYCF-E Policies and Programmatic Activities at the Central Level

As described in Chapter 3, Section 3.3 'Methods', eight key informants were initially identified of whom seven responded and were interviewed. Throughout the process, interviewees recommended the names of other stakeholders to meet. As a result, seven more informants were identified that were deemed relevant to the research, of whom five were approached and agreed to be interviewed. The twelve participants worked in a range of sectors. They included the Ministries of Public Health, Social Affairs, and Economics, the Council of Ministers, UN organisations including UNICEF, WHO, as well as representatives of the National Committee for Infant and Young Child Feeding and the Lebanese Red Cross, and an advisor from a local university with experience in policy enforcement. Posts ranged from heads of departments to technical advisors to operational managers. Not all interviewees were engaged in the previous emergency of 2006 in Lebanon, however all were involved in one way or another in the current operations of the crisis.

Through the interviews, the main topics covered were (i) existence of policies and activities related to IYCF and IYCF-E and the interviewees' knowledge and perception about these policies and guidance, (ii) extent to which interviewees perceive those policies as implemented and enforced, (iii) perceived barriers and opportunities to supporting IYCF-E. As described in Chapter 3 on methods and methodology, semi-structured interviews were transcribed and analysed. Thematic analysis based on Greene & Browne (2005) was used to generate themes and sub-themes and answer the research questions. A verification process was also adopted (See Chapter 3, Section 3.4 'Analysis'). Below are the key findings.

5.1.1 IYCF and IYCF-E policies and programmatic activities – content and implementation.

5.1.1a National and international policies on IYCF/IYCF-E.

Participants were asked about their knowledge of existing IYCF and IYCF-E policies, both at the national and institutional level in Lebanon. There was awareness amongst interviewees about the presence of "something" that regulates IYCF in Lebanon, however the level of accuracy in defining the policy or guidance varied. Some cited specific policies and laws, others were not sure what the guidance was or were only aware of international guidance but not local policies.

> *"In Lebanon, we have not adopted anything particularly in terms of laws but there are recommendations for at least dealing with the milk substitutes. We have not voted that law yet." (SS[13]4 - Technical Advisor at a private university)*

[13] SS# refers to Semi-Structured interview followed by the number of the interview.

Some interviewees, including a UN agency representative, an advisor to a Minister, and an advisor at a local university, were not aware of any national IYCF or IYCF-E policies.

A number of national and international policies and laws were reported including the Lebanese Law 47/2008, which was the most frequently cited regulation. In some cases, this was named specifically, other times referring to it as “a law”.

> *“There is the law, law of marketing of infant feeding products and utensils. This is the only legal thing.” (SS1- NGO Senior Officer / Specialist)*

The Code was mentioned occasionally, notably by one interviewee who reported being unaware of any national policies but highlighted that Lebanon had endorsed the above Code.

The BFHI was mentioned both as a policy and a programme with some indication that it was perceived as being against bottle feeding:

> *“We have several ministerial decrees about Baby-Friendly hospitals and banning bottle feeding.” (SS5 - UN Senior Officer #1)*

Other policies and laws that were mentioned occasionally included the Law issued in 1983 “*related to organising the marketing of Breast Milk Substitutes and it is a translation that is not complete of the Code*” (SS12 – CEO of local NGO). The Civil servant at the MoPH mentioned a nursery decree which includes a section on ensuring proper nutrition for infants and young children in nurseries.

Law 659 for consumer protection which “protects consumers including infants and young children through ensuring products are up to standards” was mentioned by the advisor at the Ministry of Economy. The Law refers to relevant laws when necessary.

i.e. for example when dealing with infant formula, the relevant law would be Law 47/2008.

Few interviewees mentioned policies and guidance on IYCF in emergencies and included both local and international guidance. Most were not aware of any guidance related to emergencies:

> *"Errr…. I don't know specifically I don't know but I think there are laws .... [at the] National level I think…? I'm not sure ….I think for normal situations… I am not aware of any laws specific to emergencies. No." (SS3 – Advisor at a Ministry)*
>
> *"No, laws no… [related to emergencies] at the MoPH level no…" (SS2 – Civil Servant at a Ministry #1)*

Some interviewees did cite documents and guidance related to emergencies however the naming of each varied between interviewees. The Joint Statement on Infant and Young Child Feeding in Emergencies in Lebanon (MoSA et al., 2006 and MoPH et al., 2012) was referred to as "position paper collective" or "written procedures" that includes recommendations for supporting IYCF during emergencies.

> *"Yes, in 2006 there was a position paper collective. Headed by the Ministry but all UN agencies involved about importance of breastfeeding and some child nutrition related issues. ….It was updated I think at the beginning of this crisis. It had a small component for emergencies...." (SS5 – UN Senior Officer #1)*

The Sphere Standards which are international standards for emergency response and include guidance on IYCF (Greaney et al., 2011) were mentioned by a local agency who indicated commitment to its' standards.

> *"For us, there are international standards that are used… which are the Sphere standards." (SS9 – NGO Senior Officer)*

In addition to the above-mentioned policies and guidance, one UN agency referred to its own institutional policy/mandate which upholds optimal IYCF.

> *"So in terms of [name of UN agency] ... we do not accept any milk donations, we do not distribute milk … and we are abiding by those rules… it is part of our mandate …." (SS6 – UN Senior Officer #2)*

Interviewees were also asked about existing national preparedness plans and the extent to which these plans include any IYCF policies or guidance. A "National Response Plan" which was described as a document that includes steps for emergency preparedness at the national level was cited by three interviewees (SS5, SS9, SS10). The document consists of guidance on preparedness in case of national or local emergencies and relates to plans of each Ministry.

> *"What I know that within our project we have developed a national response plan that deals with responding to disasters and emergencies for natural and man-made disasters." (SS10 – UN Senior Officer #3).*

All interviewees who referred to this plan reported that it did not include any provisions for IYCF-E:

> *"I know that at the National level there is a national plan for interventions during disasters … it is called the National Response Plan that the Lebanese Government is working on… I don't think that in any place they mention children in it…" (SS9 – NGO Senior Officer)*

One representative who is engaged in the development of the mentioned National Response Plan explained that it is not yet complete and is currently being developed by different Ministries. The representative clarified that, at the time of the interview, the preparedness/response plan was already devised by the MoSA but not yet by the

MoPH. They emphasised that whatever laws and policies exist within the Ministry these were usually upheld in the preparedness plan.

In summary, results show that IYCF and IYCF-E policies exist in Lebanon, however these are not well known to interviewees.

5.1.1b IYCF programmes and activities.

Existing IYCF programmes and activities were examined and interviewees were asked about the existence of different initiatives that focus on IYCF in Lebanon. Some participants were not aware of any initiative whereas others referred to specific activities or programmes.

Cited initiatives and programmes included The National Committee / Programme on IYCF at the MoPH which was mentioned by interviewees from a UN agency and the MoPH. The BFHI was also cited as a previously implemented programme that is no longer functional. The initiative used to be active a few years back and was referred to as a successful project.

> *"The most important step was the launching of the BFHI. This worked and in a period of five years we had 18 hospitals that are 'Baby-Friendly' … 15 hospitals in 1993 and 1996 they took the plaque [certificate] with an evaluation that is objective, three hospitals in 1998 and another three before 2001. We have 21 hospitals in which more than 25% from women [deliver]. And all small clinics, we trained the midwives on the 18 hours at the time… and they were practicing, so in effect this situation presented a very good step." (SS12 – CEO of Local NGO)*

Other activities that were reported included those done by the Nutrition Sub-Working Group led by the WFP and involving the nutrition department at the MoPH. Capacity building for the MoPH and the MoSA staff was also mentioned. It was highlighted that

efforts are being made to build capacity of health care staff at the primary health level on IYCF for both MoPH and MoSA staff, however these were cited as planned activities:

> *"Programmes related to infant and child feeding is that we are going to integrate …Yes, it's a plan… Integrate the concept of malnutrition and infant and young child feeding in the PHCs… just like we said, it is education for the health care providers. I think education is key..." (SS11 – Civil Servant at a Ministry #2).*

Activities such as the Ministry's effort to integrate breastfeeding into the curriculum of the nursing schools were also reported as part of the initiatives related to IYCF.

MoPH staff noted that there is a nutrition department at the Ministry that is functional. However, despite having nutrition for children as part of the its objectives, interviewees noted that nutrition activities were not prioritised by the department and no activities related to IYCF were mentioned to be implemented. The department was noted to focus mainly on food safety.

Activities that were not directly related to IYCF but more to nutrition in general included work on growth monitoring and screening for malnutrition which were mentioned by some interviewees.

> *[About IYCF-E program] "No, Except for the malnutrition screening that is going on now in the emergency with the [name of international organisation] supported by the humanitarian funds. They are screening the communities … that have the highest load of Syrian refugees and they are screening both Lebanese and Syrian children." (SS5 – UN Senior Officer #1)*

Additional national activities consisted of those implemented by MoSA including assistance to families with triplets which included the provision of infant formula and a poverty reduction programme which targets the most vulnerable with health and other forms of assistance that is not specific to IYCF.

In terms of IYCF-E, interviewees referred only to programmes implemented by local or international organisations that are currently active in the refugee crisis. Three main NGOs (two INGOs and one LNGO), were mentioned by interviewees as currently having activities focusing on supporting IYCF during the refugee crisis. Activities included breastfeeding support for refugees through counselling and education, provision of individual counselling and awareness sessions. Screening for malnutrition was also mentioned as one activity by an international NGO as mentioned above.
The few organisations mentioned to have IYCF-E activities were also reported to have such activities even before the crisis. IYCF-E activities implemented previously or in other contexts also included providing counselling and education. Capacity building such as training on IYCF and nutrition for HCPs was included as well as providing incentives for mothers or families with children under two years of age such as food baskets[14]. It was noted by participants that provision of incentives was key to supporting mothers with children under two years of age.

In Summary, a number of programmatic activities tackle nutrition and IYCF which are mainly implemented by MoPH or NGOs and include awareness, capacity building, and

[14] A food basket includes food items provided in the form of dry foods.

some counselling. The IYCF-E activities are mainly implemented or supported by NGOs.

5.1.1c Implementation of IYCF/IYCF-E policies.

When asked about the extent to which interviewees perceived that policies were implemented, for the most part, there was a feeling that those were not well implemented although indications for improvement in implementation were cited.

> *"I think like many laws in Lebanon it's not being implemented as it should be." (SS3 - Advisor at a Ministry)*
>
> *"I will tell you something … in principle we can say that it was not being implemented in the previous years… now it is being implemented better… we can say that there is implementation 15 to 20%." (SS2 – Civil Servant at a Ministry)*

Examples of how policies are beginning to be implemented were given by interviewees but they also emphasised the need for further enforcement. Some highlighted how policies are not being implemented and referred to examples such as the distribution of infant formula in hospitals.

> *"The law is not well implemented. Some hospitals out of their own interest and commitment do apply it but most of the hospitals don't." (SS5 – UN Senior Officer #1)*

Especially, for what relates to emergency guidance, it was emphasised that guidance was disseminated but no information about extent of implementation exists:

> *"It [the joint statement] is the basis of all infant and young children nutrition activities [within the refugee response]…. It is fully promoted. But fully implemented? there has been no real assessment done. But definitely promoted. For sure." (SS5 – UN Senior Officer #1)*

One interviewee insisted that IYCF-E policy is being fully implemented based on her experience in the field. She reported that in her experience that no distribution of infant formula is happening for Syrian refugees:

> *"We are in emergencies and I am working as a nutritional advisor, ok and I am going in all the camps and looking for the food items. No NGO is giving the milk supplements because it was a law." (SS8 – Former Civil Servant at a Ministry).*

In summary, IYCF policies are not fully implemented, although efforts to move implementation forward have been noted.

5.1.2 Barriers for implementation of policies.

Different barriers were cited as to the reasons behind poor implementation of IYCF/IYCF-E policies. These barriers can be grouped into three themes including i) political barriers and lack of prioritisation, ii) structural barriers, and iii) ethical barriers. Although separate, however it was apparent these are also fully interlinked. Also, contributing factors to each of these barriers were identified, as described below and in Figure 5-1.

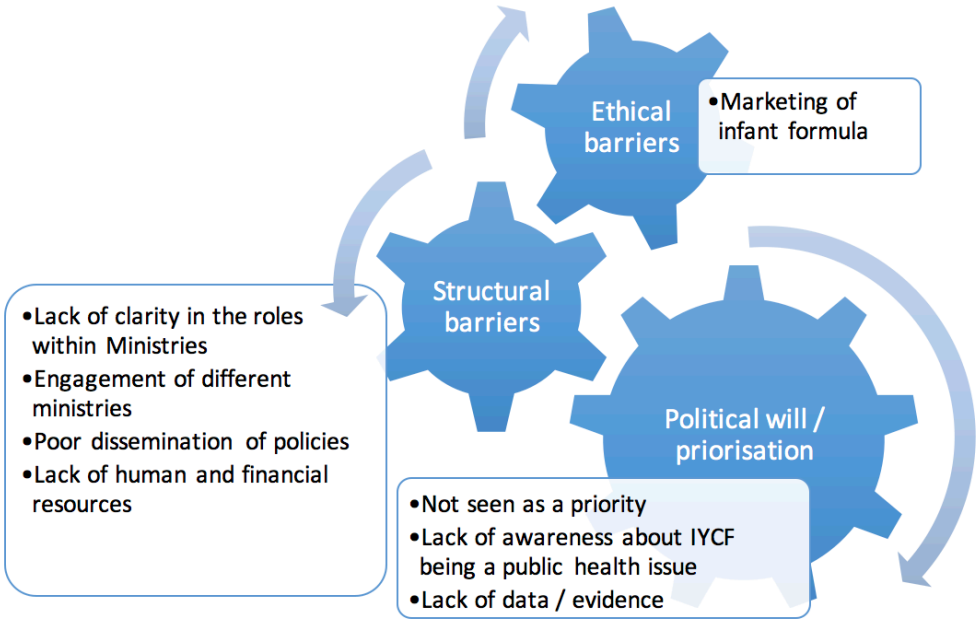


Figure 5-1 Barriers to implementation of policy

5.1.2a Political barriers, lack of prioritisation of policies and their implementation.

Interviewees highlighted a lack of both political will and prioritisation of IYCF. Political will was explained as the need to have a political decision to make the implementation of the IYCF policy a priority. It was further explained that if implementation is not prioritised, "[the file] *becomes forgotten"* due to the different priorities, especially at the MoPH:

> *"Sometimes it wouldn't be that there is a strong will … it would be that it is not in the priorities… by the time the file arrives … the subject is over … so it becomes forgotten… the Minister …is so overloaded with other things, the subject becomes neglected." (SS2 – Civil Servant at a Ministry #1)*

When asked about the extent to which IYCF is perceived as a priority responses differed, however the overall sense was that it is not a high priority. Within the same

institution, different departments warranted IYCF as having different prioritisation levels. For example, while one department had IYCF as a priority based on recommendations from the WHA, in another department it was a low-to-medium priority:

> *"The challenge we are facing is that they [MoPH] don't see nutrition as a priority." (SS6 – UN Senior Officer #2).*
>
> *"It was given to the pharmacy department so that they monitor the implementation and for them it is not a priority…." (SS2 – Civil Servant at a Ministry #1)*
>
> *"Ok, in the Ministry, I cannot talk about the [whole] Ministry …. But in the department, it is a medium priority … not a high priority……Priorities now at the Ministry is NCD … then … first of course vaccination … as something related to children it is vaccination… school health … these are the priorities… NCD for adults for sure… these are the key issues…." (SS11 – Civil Servant at a Ministry #2).*

One main reason behind the lack of prioritisation is that IYCF is not seen as a public health issue and that there is lack of awareness about the evidence to back up the prioritisation.

Interviewees highlighted this lack of awareness and knowledge about the importance of IYCF.

> *"Everybody believes that this is an issue that has to be treated…. That has to be dealt with in the dyad mother and doctor and very few people see it as an issue of public health on which legislation should be issued." (SS4 - Technical Advisor at a private university)*

Some interviewees spoke about lack of evidence for the need to support IYCF in the eyes of decision makers, especially given that Lebanon is one of the few countries in

the region to have reached the MDG for infant mortality. Two interviewees mentioned this, one of whom went ahead and suggested the possibility of using high rates of obesity as a leeway to approach the prioritisation of IYCF.

> *"Look, the data in Lebanon is not indicative of many problems in terms of nutrition. But we do have probably obesity in young children more than we expect. That could be a root cause in this bottle feeding habits because breastfeeding is very low among the Lebanese population." (SS5 - UN Senior Officer #1)*

The lack of monitoring data was also reported and others based their answers on the experience of the 2006 war where *"there was no reporting of major nutritional problems of children"* (SS4 - Technical Advisor at a private university). A number of interviewees were not aware of how prioritisation happens within their organisation.

5.1.2b Structural barriers – logistical issues with the implementation of existing policies.

Interviewees referred to a number of factors that are perceived to hinder the implementation of policies related to IYCF that were logistical and structural in nature. These factors related to the mode of implementation of the existing policy – mainly Law 47/2008 - and were grouped into the following themes: i) Lack of clarity in the roles within Ministries where different departments have different levels of interpreting IYCF policies, ii) the engagement of different ministries including the MoPH, MoSA, Ministry of Interior, Ministry of Economics, and Ministry of Justice, iii) the poor dissemination of policies, and iv) the lack of human and financial resources.

Lack of clarity in the roles of different departments at the same ministry was highlighted and even a suggestion to modify the Law to include more clarification was

suggested. For example, it was reported that there are different departments within the same institution responsible for the implementation of policies and each has their own priority and resources although their role was not always clear in the eyes of the interviewees:

> *"There should be several departments involved… in that subject…. mother and child, nutrition, if you're targeting primary health care, then primary health care department … if you're targeting the hospitals… then the department that takes care of hospitals… The pharmacy department as far as I know… gives the clearance on the import of medications…infant formula … I think it was delegated to the nutrition department…" (SS11 - Civil Servant at a Ministry #2)*

Similarly, the engagement of different ministries for the implementation of the Law was highlighted. MoPH was perceived to be the main implementer with MoSA, Ministry of Interior, Ministry of Justice as well as the Ministry of Economics contributing to the implementation of different parts of the policy. This multiplicity of authorities was highlighted as being a main barrier in the implementation of the Law including the lack of clarity in the roles and unawareness about specific obligations.

> *"There are multiple Ministries that are together involved in the implementation … for us [MoPH] … we are not the party that gives the penalties… we are the party that refers to the Ministry of Economy… Ministry of Justice … and this is something that is lacking…" (SS2 – Civil servant at a Ministry #1)*

In addition, the lack of human and financial resources was highlighted. There was a general sense that ministries are not able to cope with the requirements to properly implement and monitor the Law. The number of human resources to ensure proper follow up and monitoring is perceived to be limited.

> *"Because the government cannot play the police 24 hours a day with all the problems that are there and the limited number of staff." (SS5 – UN Senior Officer #1)*

Administrative staff responsible for the follow up at the institutional level are already overloaded with day-to-day tasks and there is a lack of "people on the ground". Interviewees mainly engaged in the implementation of the Law explained how different daily priorities take up their time and hinder their ability to consistently follow up.

Other structural barriers for implementation included the poor dissemination of policies to stakeholders at different levels and lack of awareness about them. As seen above, a number of interviewees in key positions were not aware of the policies that exist at the national level. At the same time, there were indications by some interviewees about the need to disseminate further the policies so that people at different levels are more conscious of these policies.

5.1.2c Ethical barriers.

Another barrier that was alluded to is the impact that infant formula companies have on the implementation of policies. These were grouped under the theme 'conflict of interest'. Interviewees mentioned "pharmaceutical lobbies" on paediatricians, doctors and hospitals that affected the extent to which the latter abide by established policies. Interviewees believed that the effect of companies on policy makers makes it more difficult to prioritise and enforce policies. Examples were given on the danger

of marketing of infant feeding products in the health sector given the confidence that people have in doctors and hospitals.

> *"…When the hospital has given it [the infant formula can] to us… or the doctor has told us about it… they have confidence that the doctor and hospital are more aware and more knowledgeable from what the person believes in…. they [the families] don't know there is marketing and there is business …." (SS7 – Technical Advisor at a Ministry).*

Families have confidence in the health sector and what the latter recommends or distributes would be considered trustworthy. At the same time, the challenge of addressing these "lobbyists" was also raised given the power they have.

> *"The most serious obstacle to any progress on this issue are the pharmaceutical lobbies, they are the ones who are distributing free items and pushing pharmacists to talk about this and pushing the paediatricians to talk about this. They are the ones who just leave baskets of milk substitutes in the delivery rooms and stuff like that. These are the people who need to be targeted, except they are very powerful lobbyists." (SS4 - Technical Advisor at a private university).*

5.1.3 Participants' recommendations for improving implementation of policies.

The key informants' main recommendations for improving policy implementation included i) prioritisation of the Law, including lobbying for it and building the evidence base; ii) building public and professional awareness, including capacity building; and iii) practical steps for addressing structural barriers.

5.1.3a Prioritisation of the Law and political will.

To address barriers for implementing policies, one main recommendation that was highlighted was the importance of prioritising the implementation of policies and Law 47/2008. Emphasis was put on the role of ministries and the public sector. It was explained that a "political decision" needs to be made in order for the Law to be implemented.

> *"There needs to be a political decision… the will and for him [the Minister] to … put in the priorities this subject…" (SS2 – Civil servant at a Ministry #1)*

However, for prioritisation to occur, interviewees referred to several actions that would contribute to ensuring the Law is put on the agenda of implementers.

Lobbying / pressure from civil societies and the community.

A pre-requisite for prioritising the implementation of the Law was lobbying, advocacy and community pressure. More than one interviewee emphasised the role that civil society and communities have in pushing for the prioritisation and therefore the implementation of policies.

> *"You know, I went one month to the US and this is what I discovered… that in the US the government is lazy to an extent that nothing makes them work without the lobbying… for me I think the starting point is in having good local NGOs for them to do from one side education for people and from the other side to push on the members of parliament… because this is the only thing that will get us to results…" (SS7 – Technical Advisor at a Ministry)*

Examples were given from the present situation where pressure was put on the public sector for the enforcement of the Law both in breastfeeding as well as smoking.

Building the evidence.

Another identified opportunity for prioritising the implementation of the Law was building the evidence and documenting the need. It was emphasised that besides anecdotal evidence, there is no proof for the need to prioritise the enforcement of the Law and support for IYCF. There is a perception that there is no documented evidence that IYCF is a gap and that there is a need to provide proof that IYCF is a priority and that contributing to improving IYCF will have a tangible effect. Therefore, assessing the risk of not supporting IYCF was highlighted as key in documenting and building the evidence of the problem.

> *"Document first, because it's all anecdotal. The last breastfeeding assessment in Lebanon dates back to 25 years ago." (SS5 - UN Senior Officer #1)*
>
> *"Risk analysis should be based on a risk assessment first and the risk assessment needs data … we have a data problem in Lebanon." (SS7 – Technical Advisor at a Ministry)*

In summary, there is a need to prioritise the Law for it to be further implemented through lobbying and advocacy for IYCF as well as building the evidence for the need to support IYCF and implement policies.

5.1.3b Capacity building and public awareness.

Interviewees emphasised the importance of building public awareness both at the professional and community levels as key to enforcing policies:

> *"The most important problem or gap… are in the knowledge level of all stakeholders… I mean I ask you today … how many nurses know about this law? I teach nurses and there are plenty who have not heard of it." (SS7 – Technical Advisor at a Ministry)*

"And the problem was doctors, doctors don't know... this doctor, he's Syrian, he studied medicine since 20 years. Or 25. And still following the old [curriculum]… because I told him the reference (WHO) to go there and ….to follow up … it was ok." (SS1 – NGO Senior Officer / Specialist)

Community awareness was highlighted including awareness for mothers and fathers as a way to empower them and make them aware of their rights in terms of IYCF and therefore contribute to its enforcement. Additionally, professional awareness was emphasised to counteract the marketing of formula companies and ensure consensus that IYCF is a priority and a public health issue. This was perceived to boost the efforts pushing for the prioritisation of enforcement of the Law.

5.1.3c Addressing structural barriers.

Interviewees, mainly those involved in the implementation of policies, suggested some approaches to address structural barriers. These included revising the existing policy in order to unify decision making and implementation under one umbrella.

"So, we have to, for us [MoPH], when we modify this law not to modify the content… but modify the mode of implementation because it has gaps… …when you put a law, you need to monitor this law…" (SS2 – Civil Servant at a Ministry #1)

For example, instead of having different entities involved in the implementation, it was suggested that one entity be responsible. Other activities included wider awareness of the Law requirements, engaging key stakeholders (both public and private,) and monitoring the implementation of the Law. Given the lack of awareness of policies, effective dissemination of the Law and relevant policies amongst

institutions and facilities was suggested as a way to address structural barriers. Primary health centres and hospitals were mentioned as main facilities.

> *"I think they [health centres] should be reminded of the law." (SS11 – Civil Servant at a Ministry #2)*

In addition, casa doctors[15] and other health professionals were also cited as targets for dissemination of policies as well as local and international organisations.

Engaging different public entities that provide frontline support was indicated as another step to address structural barriers. For example, it was highlighted that MoSA Social Development Centres (SDCs) can play a role in the monitoring of the implementation of the Law. SDCs provide social services within communities and can provide monitoring support.

> *"Well the NGOs working through our SDCs … so they could also have an impact also on a higher level [on distribution of infant formula]. They could have control, we try to have control but it is not always the case." (SS3 - Advisor at a Ministry).*

Municipalities were also mentioned at different occasions as potentially having a role in monitoring and enforcement of policies especially organisational activities.

> *"You know a municipality is like a government inside the area… so they can play [a role]… The Ministry of Interior….the directorate of municipalities because, the micro… is there…." (SS7 Technical Advisor at a Ministry).*

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[15] A "Casa" is similar to a district in Lebanon. Lebanon has 27 Casas and 7 Governorates. Each governorate is divided into different Casas. Casa Doctors are doctors representing MoPH in each of the Casa or district.

At the level of the MoPH, primary health centres, casa doctors and health inspectors were listed as key players that would potentially have a role in monitoring and implementation of IYCF policies both in normal and emergency situations:

> *"I think within the existing structure… through the casa doctors [we can monitor distribution of infant formula]. And we have the health monitors and the casa doctors so these are the most decentralised who can have a say in the subject." (SS11 - Civil Servant at a Ministry #2).*

Some key players were also listed as having a role in ensuring compliance with policies related to acceptance and distribution of donations. These include the department of customs regulating the entry of goods, the Higher Relief Council, the Ministry of Economics regulating the quality of goods provided to consumers, and the Ministry of Interior through municipalities in the regions regulating and monitoring distribution of goods.

The role of UN agencies was also highlighted to address structural barriers. Agencies supporting institutions and service providers can make enforcement of policies a requirement for receiving support or funds.

> *"They [NGOs and UN agencies] can [enforce the law] yeah yeah because they are the people who are supporting... [paying] They [NGOs and UN agencies] are supporting, especially the international ones. They are supporting the hospitals. … Always, when you have something in return, … you tell them I don't give [money] … The same for the government. They could enforce this. If you are not Baby-Friendly, I will not put my patients at your hospital." (SS1- NGO Senior Officer / Specialist).*

An example was given in the case of UNHCR supporting hospitals and making sure the latter abide by IYCF policies.

5.1.4 Barriers and challenges for supporting IYCF.

While responding to barriers on implementation of policies related to IYCF, interviewees also emphasised barriers related to ensuring adherence to recommended IYCF practices in general or during emergencies. Reported barriers similarly included i) lack of awareness on IYCF amongst mothers, ii) lack of support from professionals, and iii) lack of protection from the marketing of infant formula (poor implementation of the Law).

5.1.4a Lack of awareness.

Interviewees emphasised that there is lack of awareness amongst the communities in general and mothers in particular about existing recommendations. It was reported that the culture is a formula feeding one and that misconceptions exist about breastfeeding and body image, breastfeeding and stress amongst others. These were most common during emergencies. There was a perception amongst interviewees that the lack of awareness is negatively affecting practices related to IYCF.

> *"In emergencies, …even the mother she is always afraid that her milk is not enough due to stress and she doesn't want to put the child under the stress that she is suffering." (SS6 – UN Senior Officer #2)*

5.1.4b Lack of support.

The lack of counselling and professional support was highlighted on many occasions with emphasis on a lack of support from paediatricians. It was explained that doctors including paediatricians are regarded as the sole authority for providing advice to

mothers; any other advice by nurses, midwives or other health professionals was disregarded if this contradicted the doctor's advice.

> *"…you know, the doctor patient relationship is very strong in this country and if the doctor promotes [infant formula] then the woman would most likely do it." (SS4 - Technical Advisor at a private university)*

At the same time, it was made clear that paediatricians and other doctors frequently give the wrong advice regarding infant nutrition and may even promote infant formula through uncontrolled prescriptions.

> *"You have the medical doctors…they are not all … abiding by the recommendation of exclusive breastfeeding and they are not always abiding by the progressive introduction of solid food recommendations etc. so they come from different medical schools and medical thoughts." (SS5 – UN senior officer #1).*

> *"Especially in the hospitals and with the physicians. You see doctors giving the milk although they are supposed not to give." (SS8 – Former Civil Servant at a Ministry)*

Time and awareness about IYCF by other health care staff (e.g. nurses and paramedical staff) was also highlighted as low especially during the pre and postnatal period. Absence of a supportive environment especially for the working women was also highlighted. It was perceived that there is a lack of proper facilities and conducive environment to support working mothers especially amongst Syrian refugees who are in financial need.

> *"Many of the refugee women are doing daily work. Employment on daily basis so if they miss a day their income goes down and they have to work so it's financial issue …" (SS5- UN Senior Officer #1)*

5.1.4c Lack of protection from marketing of infant formula.

Receipt of gifts in the form of infant feeding products from hospitals as well as prescriptions of infant formula by doctors were described as barriers to reaching recommended feeding practices.

> *"The problem that even if we promote for example IYCF and any other behaviour, if somebody came from outside and distributed the milk that's it, as if we didn't do anything." (SS6 – UN Senior Officer #2)*

Interviewees highlighted the dangers of marketing of infant formula especially in health facilities and the impact this practice has on infant feeding choices. The marketing of formula companies and lack of awareness about the Law were all mentioned as affecting a mother's decision to continue breastfeeding.

> *"The person who is not aware will think that this [the formula can from the hospital] is profit… and 'This is something very good… so let us try it… where is the problem?'" (SS9 – NGO Senior Officer)*

5.1.5 Barriers related to IYCF programming.

Specifically, when it comes to IYCF programming and mainly in emergency situations, interviewees reported some challenges including lack of sustainability and reliance on international organisations, difficulty accessing beneficiaries, and lack of coordination. Interviewees perceived reliance on external donors and external funding for programming in general and IYCF specifically as affecting the sustainability of programs. BFHI was given as an example which was launched and then halted due to lack of funding:

> *"I give you for example the BFHI, the Italians donated some money, it was revived for some time, although the programme is in the Ministry, WHO donated money*

in 2009, it worked for a year and a half the duration of the program, but they don't monitor so they cannot sustain." (SS5 – UN Senior officer #1).

Reliance on international organisations was also referred to in terms of provision of guidance and programmatic planning. Also in terms of barriers to proper implementation of IYCF programs, it was reported that especially during emergencies, coordination was lacking both with the government and amongst organisations. It was emphasised that more coordination was needed to ensure consistent implementation of IYCF services.

5.1.6 Participants' recommendations for IYCF-E support and preparedness.

The main recommendations for preparedness in terms of IYCF-E included supporting IYCF in non-emergencies and developing a national plan or strategy for preparedness. By supporting IYCF in non-emergencies, interviewees highlighted the importance of ensuring policies and regulations are implemented, capacity building is conducted targeting professionals in addition to community awareness.

5.1.6a Building a good base and supporting IYCF in non-emergencies as a key preparedness step.

A number of interviewees highlighted the importance of supporting IYCF in non-emergencies as a key step for preparedness.

"We all know ... the studies across the world… that an investment of one dollar pre disaster, is saving the seven dollars during disaster … I mean each investment, one dollar I put …. before the disaster, I am decreasing the expenditure of seven dollars … during the disaster…" (SS9 – NGO Senior Officer)

They indicated that if communities are not accustomed to a certain behaviour then it would be difficult to change that behaviour during emergencies, hence the importance of supporting IYCF during non-emergencies.

> *"Breastfeeding, I mean you know… if it's not there in peace it won't start in war... In the context of the overall emergency I think what is important is to protect the mother and the child. Once they are in a protected environment they will probably revert to whatever there was before the emergency so really it depends on what they were doing before the emergency." (SS4 - Technical advisor at a private university)*

This was perceived to be both related to IYCF (e.g. exclusive breastfeeding) as well as the implementation of existing policies. For example, an interviewee noted that if laws are implemented in non-emergencies, implementation would be easier during emergencies.

> *"We now have a reactive system; we need to make it proactive." (SS7 – Technical Advisor at a Ministry)*

Interviewees emphasised ways to support IYCF in general including i) establishment and implementation of IYCF policies, ii) developing a national plan or strategy, and iii) building public and professional awareness. Suggestions such as family planning and maternity protection were also highlighted.

Establish and implement policies to support IYCF and IYCF-E

One main suggestion which was perceived to support appropriate IYCF included the implementation of laws to protect families and mothers from the marketing of BMS. Interviewees highlighted the importance of banning distribution of infant formula and

regulating the advertising of BMS and ensuring that advertisements are not misleading in general:

> *"There should be a law… or penalty. A penalty that is really like worth it." (SS6 – UN Senior Officer #2)*
>
> *"The first thing that needs to be done is you need to think that… in general when there is an emergency … the mother should breastfeed more …. for us we should have put … like a condition… not to give milk … on the contrary…" (SS2 – Civil Servant at a Ministry #1)*
>
> *"In emergencies… first there should be a clear law… for emergencies… that forbids the entry or the donations in that subject." (SS10 – UN Senior Officer #3)*

The importance of enforcing the Law both during normal and emergency situations was suggested as a main contributor to supporting IYCF during emergencies. It was also indicated that there should be a policy that is specific during emergencies that takes into consideration the specificities of the emergency context.

> *"For emergencies, the government should apply the law - The main recommendation is to empower [enforce] the policy. No, to make a policy first, and empower the law, because if you don't empower the law…" (SS1 - NGO Senior Officer / Specialist)*

Another suggested opportunity to improve IYCF that was highlighted, is the modification of the maternity protection policies. One interviewee stated that maternity leave needs to increase to six months to accommodate breastfeeding and ability to care for one's baby. On the other hand, the importance of prioritizing IYCF not only by the government but also by organizations during emergencies was reported.

Building professional awareness

Another key recommendation for supporting IYCF as a preparedness activity was providing awareness and capacity building for health professionals with an emphasis on doctors. It was noted that the role of doctors, specifically paediatricians is of utmost importance in providing proper and correct support:

> *"Education to mothers and to health care providers… the focus point of the intervention should be the paediatrician because whatever the nurse said, whatever the health care worker says, whatever the midwife says… they will not grasp it as much as what they will get from the doctor… so we have this culture… even if it was the nurse… whatever she was saying…. we listen to the doctor…" (SS11 - Civil Servant at a Ministry #2)*

It was also noted that there is a need for more professional skilled labour including support for lactation. Interviewees highlighted challenges with hospitals and health professionals and suggested working on improving professional skills. Organisations such as the Order of Physicians and Paediatricians were mentioned as entities to address and target.

Build public awareness

Interviewees explained that if communities do not have the proper awareness and sensitisation about IYCF during non-emergency settings it will be difficult for them to continue ensuring adequate IYCF during emergencies. One interviewee even specified the importance of using tailored behaviour change communication.

> *"There are people who don't know … so they don't care… and there are people who know and they don't care and there are those who know and they care…. For me if a person has the knowledge but does not have the motivation… I would use*

tools that are different than those who have ignorance." (SS7 – Technical Advisor at a Ministry)

Therefore, awareness for mothers was suggested as a preparedness activity that would empower mothers and make them aware of recommended IYCF practices. It was highlighted that mothers need to be convinced of the importance of appropriate IYCF. The role of mothers was highlighted as key in providing the proper care for children. Just as in any kind of care, it was mentioned that a mother's role was key no matter what policies are in place:

"The most important thing to work on is to work on the mind of the mother… she is the base… not the government neither the Baby-Friendly hospital or anything... because in all countries in the world… it showed that if the mother… you were able to work on her awareness… because … you are entrusting her with the most precious [thing]... which is the health of her child... and his safety… when she knows to what extent … breastfeeding is important and to take care of the nutrition of her child until a certain age… to what extent she is doing an investment in his health… in order to decrease a lot of things on him. I think no mother will not do this… so I go back and say awareness, awareness …" (SS2 – Civil Servant at a Ministry #1)

5.1.6b Develop a national preparedness plan that includes IYCF-E.

It was emphasised that investments pre-emergencies have higher revenues than those during emergencies, highlighting the importance of preparedness plans. Interviewees reported that a national preparedness plan that includes provisions for the support of IYCF during emergencies is needed. The plan would engage different

stakeholders including ministries and organisations and would take into account monitoring of the Law.

> *"What is missing is the plan with clear objectives that are implemented and to have accountability." (SS12 – CEO of Local NGO)*

Suggestions to have existing partnerships with organisations and ministries and the importance of having plans trickle down to municipalities, PHCCs, SDCs, and local organisations such as Lebanese Red Cross were also mentioned.

> *"There needs to be a written plan… there needs to be processes that are specific… if we don't think about it now... we need to learn from this time to write a plan for another time… this should be at the National level… the council of ministers should have a plan… a very big plan… and within in… this … I mean … err.. a small part…. A small point would be this... It should have specific basis… and this is not present…" (SS2 – Civil Servant at a Ministry #1)*

One main suggestion included having standard operating procedures (SOPs) for supporting IYCF including distribution of infant formula and food support. It was indicated that such SOPs would be disseminated to actors in the field to abide by and would serve as the standard of care on IYCF. SOPs would cover also donations from outside the country as well as interventions within the country:

> *"There are no standard operating procedures for donations of food… they don't exist. They should exist. … if you want to import infant formula they should be with these specifications and they should be labelled that this is for more than six months …, you know, the specs, and this is how you do it and this is how you distribute it, this is how you… these are the people eligible to use it for the exceptional part, it should be very clear how it is done." (SS5 – UN Senior Officer #1).*

The higher relief council (HRC), a national body, was reported as being a key actor in ensuring preparedness and abidance by IYCF policies. It was suggested that engaging the HRC in preparedness plans to be ready for emergencies and support IYCF is an important step. Other suggestions included having an emergency stock and technical specifications for food and infant baskets as preparedness actions.

Section 5.2 Discussion of Findings at the Central Level

This section discusses results from the semi-structured interviews with key stakeholders and the document review. It gives insight into the Case (IYCF-E policies and programmatic activities in Lebanon) at the central level.

5.2.1 IYCF-E policies and programmatic activities (description).

Overall, there seemed to be a consensus about the presence of national policies related to IYCF but not so much about IYCF-E and awareness about such policies varied. Many times there was uncertainty about what policies exist especially those related to emergencies. In Lebanon, a joint statement on IYCF-E was issued in 2012 that includes guidance on IYCF in emergencies in the context of the crisis (MoPH et al., 2012). This statement was referred to in the interviews by a number of stakeholders, however using different naming. In addition, Lebanon has endorsed the Code through Law 47/2008 which regulates the marketing of BMS (RoL, 2008). The only stakeholders that were aware of IYCF policies were those from within MoPH, UN agencies, and one other ministry and all mentioned a main policy which is Law 47/2008. Key stakeholders from the MoSA, the Lebanese Red Cross, the Council of Ministers, and technical advisors were not aware of the presence of any policy related to IYCF or IYCF-E. Informants often claimed to be aware of policies, but lacked precise knowledge of the content of the documents often referring to “banning of infant formula” as opposed to the regulation of the marketing of infant formula which is referred to in the policy documents. Similar situations have been reported when examining other health policies. For example, Prior (2014) examined policies related to the secondary prevention of Coronary Heart Disease (CHD) in Ireland and saw similar lack of

knowledge amongst policy makers. However, gaps in dissemination of policies are most often found at the service provision level rather than at the central level (WBTI & UNICEF, 2014).

The lack of knowledge about existing IYCF and the IYCF-E policies and their content amongst key stakeholders shows that although certain policies have been put in place, these have not been properly disseminated or promoted or explained other than within specific governing bodies. Dissemination to ministries other than MoPH and key stakeholders appears to be lacking which may affect the extent to which policies are implemented. This is especially if the lack of knowledge is amongst key implementers or influencers of implementation. At least one interviewees held a management position in an agency that played a key role in emergency interventions yet was not aware of existing policies. This lack of knowledge prompts the opportunity to further disseminate existing guidance and policies related to IYCF and IYCF-E.

There were no clear plans interviewees were referring to that describe IYCF or IYCF-E programming in Lebanon. There was also no indication that MoPH has a clear IYCF strategy for IYCF programming although efforts to develop one were noted. At the time of writing this report, the author was aware that an IYCF strategy was going to be drafted however no further information was available. Overall, a number of initiatives and activities were cited including capacity building and awareness, with those being implemented by MoPH and NGOs being the most prominently mentioned. It was striking that the MoPH nutrition department was not engaged in any of those initiative.

When it comes to preparedness, it was very clear that IYCF-E was totally absent from any existing preparedness plans as mentioned by interviewees. This is in line with results from the World Breastfeeding Trend Initiative (WBTI) (Gupta et al., 2013). As mentioned in Chapter 2, Section 2.2, the initiative includes indicators for the monitoring of the GSIYCF. For emergencies, the initiative measures the following criteria i) whether the country has a policy, ii) whether this policy has an implementation plan, and iii) whether the country has an emergency preparedness plan that includes provision for supporting IYCF-E. Gupta et al. reported that Lebanon scores 3/10 in WBTI for infant feeding in emergencies given that there is a lack of emergency preparedness plans that include provisions for IYCF-E. In fact, as mentioned by Gribble and Berry (2011), breastfeeding is rarely if not never mentioned in emergency preparedness plan especially in developed countries.

Overall there was a sense of agreement that existing policies needed to be better implemented. Which means that Law 47/2008 was not fully enforced and needed to be better implemented. Even the one interviewee who insisted that the policy was implemented when targeting refugees, agreed that it was not being implemented in hospitals. Therefore, poor yet progressive implementation was noted, especially from the side of MoPH. Progressive given that a perceived improvement in implementation was noted by stakeholders. However, it was clear that much efforts are needed to enforce and implement existing policies especially in what relates to emergencies. Compliance with IYCF and IYC-E policies is documented by IBFAN which reports on violations by formula companies and the state of implementation of the Code (IBFAN, 2016). However, as noted by Forsyth (2013), non-compliance to IYCF policies

(particularly the Code) encompasses not only the formula industry but other actors as well.

5.2.2 Barriers for Implementing IYCF and IYCF-E Policies and Activities

It seemed as if each of the stakeholders, depending on their position, highlighted barriers relevant to their responsibilities. Most of the structural barriers were mentioned by interviewees engaged in the implementation of policies related to IYCF. Political barriers and ethical barriers were highlighted by a varied range of interviewees who have experienced such barriers.

This compilation of barriers and opportunities are not new to the literature. Pérez-Escamilla et al. (2012) in their AIDED [16] framework identified key barriers and facilitators for scaling up of programmes on breastfeeding which match a number of those identified through this study.

Lack of political will and poor prioritisation of the implementation of the policy was one of the mains barriers perceived by key stakeholders as hindering the implementation of policy and supporting IYCF. It seems as if IYCF has gained increased prioritisation compared to the past at least by the MoPH. That is why, political will and prioritisation is seen as both a barrier but also an opportunity. Political will is a key component of the BGM developed by Perez-Ezcamilla et al. (2012) whereby it is

[16] From Pérez-Escamilla et al. (2012): "AIDED includes five nonlinear interrelated components: 1) assess the landscape, 2) innovate to fit user receptivity, 3) develop support, 4) engage user groups, and 5) devolve efforts for spreading innovation."

considered necessary to enact legislations and policies related to breastfeeding. Lack of political will has also been documented as a barrier for the implementation of IYCF policies including the Code (Forsyth, 2013). Cattaneo (2004) highlighted that political will was the most important factor hindering promotion, support and protection of breastfeeding. Specifically, in Lebanon, lack of political will was highlighted by Akik (2014) in her doctoral research as a key barrier for the implementation of Law 47/2008 as well as in a published policy brief later in 2015 (Akik, Ghattas, & El-Jardali, 2015).

Findings show that IYCF policy implementation is not prioritised due to different reasons one of which is the *lack of data and evidence*. The lack of evidence on the value of supporting IYCF including breastfeeding has been noted to contribute to the lack of prioritisation of IYCF amongst policy makers in developed countries (Salmon, 2015). Although Lebanon is not a developed country, still, many of its characteristics have some resemblance such as maternal mortality rate which is close to the average rate in high income countries (MoPH, 2015a). Hajeebhoy et al. (2013) confirms that investments in IYCF programmes and policies lag as a result of lack of awareness on the importance of IYCF. They found that "evidence-based advocacy design" is key to improving prioritisation of IYCF and supporting implementation and design of IYCF programmes. In this study, a key element that was repeated is that there is no 'evidence' to support the need to work on IYCF.

Being a middle income country with low mortality rates and having achieved targets related to the MDGs, IYCF was not seen as a priority for the government. At the same time, having documentation of the gaps and needs related to IYCF was seen a key pre-

requisite for prioritisation of IYCF. Although the latest figures on IYCF indicators - which date back to 2009 - do show poor IYCF practices (CAS & UNICEF, 2009), still it seems that MoPH's prioritisation process relies mainly on the MDGs (maternal and infant mortality rates) as well as causes of death which are primarily linked to NCDs. As reviewed in Chapter 2, Section 2.1 'Infant and Young Child Feeding – Health Perspectives', there is a direct link between infant mortality and IYCF practices and indicators however, supporting NCD has been given a higher priority. Since the link between NCDs and early nutrition has been noted both by key informants and throughout the literature, it might be worth advocating for IYCF through the angle of NCD prevention. In fact, this was one of the recommendations of key informants. In addition, information related to the value of supporting IYCF in prevention of health costs could also be an outlet through which policy makers might consider supporting IYCF. As noted by Renfrew et al. (2012), investments to support breastfeeding in particular will contribute to a rapid financial return on investment including a decrease in chronic diseases, indicating a need to advocate further for IYCF through an evidence based modality.

Structural barriers are mainly linked to the clarity of implementing existing policies. A number of structural hurdles were mentioned which show that there is no clear modality for implementing existing policies. Having a number of ministries involved in enforcing the IYCF policy and more so, having more than one department at one ministry be engaged in the implementation can be considered a recipe for failure in implementing the policy. A UNICEF (2013a) review of programmes in six countries reported that one of the main factors influencing breastfeeding outcomes was

coordination. The report showed that in cases where there is adequate coordination, such as the Philippines, the IYCF agenda moved forward (UNICEF). However, in other countries where IYCF was scattered across different ministries and there was lack of clarity in roles and responsibilities, the results were often lost momentum and inefficient use of resources.

The power of *marketing of infant formula* and other infant feeding products was considered a major barrier for implementation of IYCF policies. The influence of infant formula companies has been shown to affect breastfeeding practices (Piwoz & Huffman, 2015) and evidence of efforts from BMS manufacturers influencing local feeding policies has been reported in a number of LMICs (Kean, 2014; Mason, Rawe, & Wright, 2013). One of the main barriers identified in the review conducted by Pérez-Escamilla et al. (2012) was the unethical marketing of infant formula which was cited by seven sources. Akik (2014) also identified aggressive marketing by BMS companies as a key barrier to IYCF support in Lebanon.

For interviewees who were less aware of the policies, these highlighted barriers related to supporting IYCF in general including lack of public awareness about IYCF, lack of support for breastfeeding and lack of protection from the marketing of BMS. Evidently, the latter means lack of implementation of relevant laws that protect from the marketing of BMS.

5.2.3 Plausible Approaches for Supporting IYCF/IYCF-E Policies and Activities

The main opportunities stemming from the analysis at this level include the need to instil and implement legislations related to IYCF and IYCF-E and building professional and public awareness. These actions lead to forming a base for supporting IYCF in non-emergencies which is considered key in emergency preparedness. In addition, the establishment of emergency plans that include provisions for IYCF-E is an important opportunity for preparedness. Figure 5-2 is a schematic presentation of the identified opportunities stemming at the central level.

The presence of essential legislation and the implementation of policies and guidance (#e in Figure 5-2)is key to supporting IYCF and IYCF in emergencies. Policies not only linked to the Code but also related to maternity protection were highlighted as needed to support breastfeeding and ability to care for one's infant.

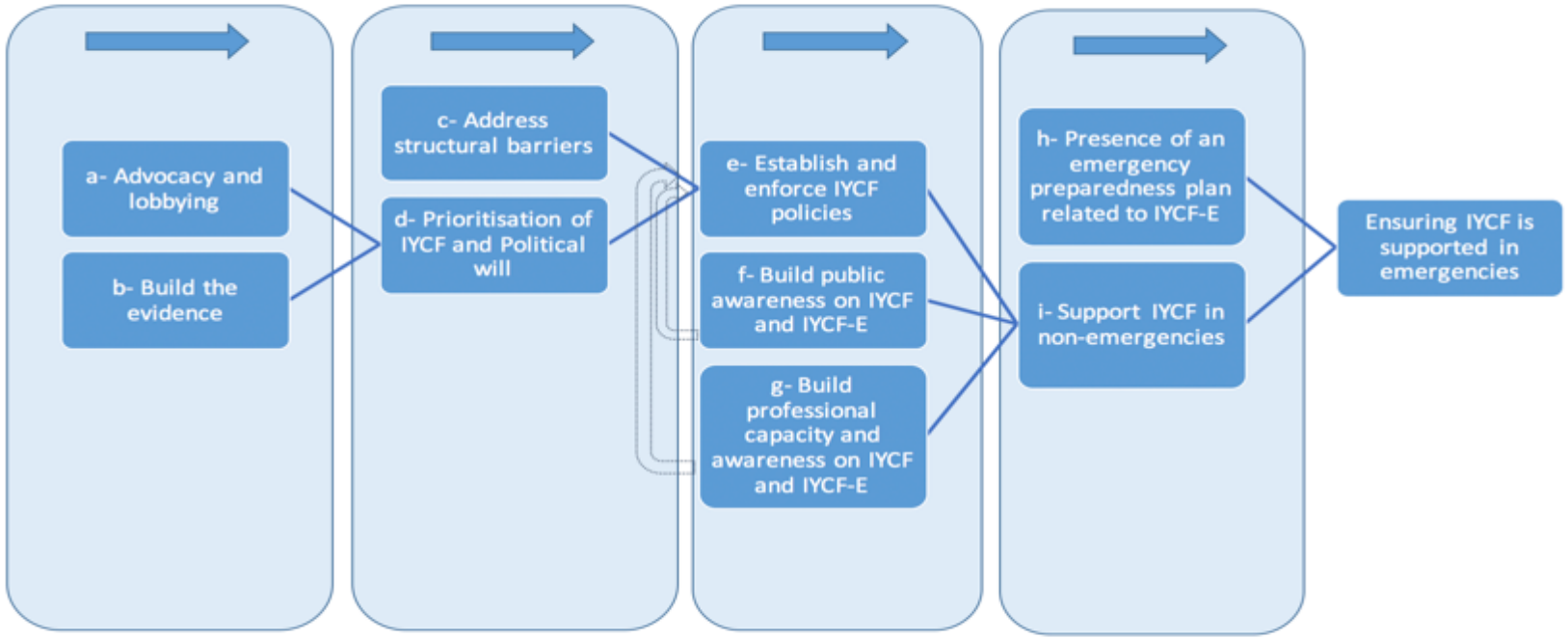

Figure 5-2 Opportunities for supporting IYCF in emergencies stemming at the central level

Prioritisation and political will (#d in Figure 5-2) were regarded as prerequisites to supporting the implementation of existing policies and recommendations to contribute to improved prioritisation of policies and programmatic activities. As previously mentioned, Pérez-Escamilla et al. (2012) includes political will as an integral part of the Gear Model where it is considered as a key pre-requisite for the scale up of breastfeeding at the country level.

Lobbying and advocacy from civil societies (#a in Figure 5-2) to the MoPH specifically were mentioned on a number of occasions and it appears that in order for MoPH to move on a community health cause, there are expectations that this should stem from a bottom up approach. It seems that the Ministry has a reactive approach to pressure from civil society. Examples were given during the interviews of a local NGO putting pressure on the Ministry to follow up on violations to existing IYCF policies. This was also reported by Akik et al. (2015). Advocacy and lobbying both are part of the GNC strategy where it is recommended that organisations advocate within government for the support of IYCF (GNC, 2014). This highlights the potential of a champion in IYCF who would play the role of advocating and lobbying for the implementation of policies. Specifically, in relation to IYCF-E, this concept of championing has been discussed in different situations where it has been linked to the success of certain activities and national initiatives. For example, UNICEF's guide for the adaptation of the IYCF counselling cards highlights the importance of having a "champion who takes the lead" and is considered the "driver" to influence the participation of others (UNICEF, 2013a). UNICEF also found in examining IYCF programmes in six countries

that IYCF champions that were dedicated to the promotion, support and protection of breastfeeding have contributed to moving the IYCF agenda forward. Hajeeboy et al. (2013) showed how in Bangladesh the presence of a champion (either an individual policy maker or an entity) contributed to IYCF policy advocacy and advancement. It could be that the presence of such a champion in Lebanon would contribute to improving policies and programmatic activities on IYCF. Advocacy and political will are both main constructs of the BGM contributing equally to the scale up of breastfeeding (Pérez-Escamilla et al., 2012).

Another opportunity for improved prioritisation was *building the evidence* for the value of supporting IYCF (#b in Figure 5-2). As discussed above, building the evidence could be by highlighting the impact of supporting IYCF on NCD prevention and emphasising the financial implications of such interventions amongst other opportunities.

Plausible approaches for supporting the implementation of existing policies also include addressing the structural barriers (#c in Figure 5-2) that hinder the enforcement of these policies. There is a need to ensure that existing policies have clearer implementation plans including well defined responsibilities and roles within ministries and between ministries.

Capacity building (#g in Figure 5-2 of this chapter) and *building public awareness* (#f in Figure 5-2) were identified as leeway to ensure support for IYCF in normal and emergency situations but also to ensuring enforcement of legislations (dotted lines).

This is in line with the GSIYCF where promotion and support make up an integral part of IYCF interventions. In different IYCF and IYCF-E programming guides, capacity building, training for health care professionals, awareness for mothers and community awareness are all main components of IYCF/IYCF-E interventions (Richardson & Walters, 2014; UNICEF, 2012; WHO, 2004). Capacity building in this study was highlighted as essential specifically for doctors given their influential role towards mothers. In fact, the weight given to the information provided by doctors has been reported to be much higher than that given by other health care professionals such as nurses, midwives or dieticians. Mothers seem to "listen" more to the information provided by doctors. Situational analyses of IYCF policies and programmatic activities in six countries found that there is a need for resources to be available as well as capacity building on implementation of IYCF activities and monitoring of IYCF programmes (Wuehler & Biga Hassoumi, 2011; Wuehler & Coulibaly, 2011; Wuehler & Hafel Ould Dehah, 2011; Wuehler & Nadjilem, 2011; Wuehler & Ouedraogo, 2011; Wuehler, Wane, & Thierno, 2011). This is similar to findings from the key informant interviews in this study where the latter strongly recommended capacity building and suggested ways to ensure monitoring of policies and programmes.

Awareness for mothers pre- and post-partum, and public awareness about breastfeeding in particular, was seen as key to supporting IYCF and contributing to advocacy. Mothers' empowerment through awareness and provision of knowledge was perceived as strategic to ensure a successful infant feeding journey. The GSIYCF highlights the importance of promoting optimal IYCF through public promotion campaigns as well as mother support (WHO & UNICEF, 2003). Recently, a review by

Balogun et al. (2016) reported that ante-natal health education by health care professionals contributes to improvement of infant feeding practices notably the early initiation of breastfeeding which in emergencies is considered crucial for neonatal survival. The lack of awareness amongst mothers about the Code was highlighted by Kirk, Sim, Hemmens, and Price (2012) when examining the implementation of a breastfeeding policy in Nova Scotia in Canada. The study found that a main recurring theme was the lack of understanding around the Code amongst mothers, where the latter perceive receiving infant formula or a bottle as gift to be pleasant and helpful. On the hand, one would argue that it may not only be mother's awareness about policies but rather the beliefs about formula. The socioecological model emphasises the role of education but also the importance of social factors and influences such as family members and other cultural norms in shaping behaviour (Sharma, 2016). It is therefore important to acknowledge that it is not only mothers that need to be targeted, but also the different influencers that may shape her beliefs such as mothers in law, husbands and other family members. Findings at the central level emphasise the need to work at the level of mothers and families in tandem with working on organising marketing as per established guidance.

Having an *emergency preparedness plans* (#h in Figure 5-2) that includes provisions for IYCF-E is a key step highlighted both by stakeholders and concluded from the fact that IYCF is not considered in existing emergency preparedness plans. SOPs for implementation of IYCF services during emergencies are needed and interviewees proposed a number of practical ways to enforce policies including engaging potential

entities to monitor the implementation. This is also in line with recommendations from the GNC Strategy and other relevant IYCF-E guidance (GNC, 2014).

5.2.4 Conclusion

Findings at the central level show that although IYCF and IYCF-E policies do exist, however these need further enforcement through ensuring that provisions are put in place by governments including prioritization and monitoring of implementation. There are barriers that hinder the implementation of existing policies and the support of IYCF that need to be addressed through advocacy, building the evidence about the importance of IYCF and building public and professional awareness.

Chapter 6 IYCF-E POLICIES AND PROGRAMMATIC ACTIVITIES: FINDINGS AT THE ORGANISATIONAL LEVEL

This chapter presents findings from the survey questionnaire administered to NGOs to give insight into the Case at the organizational level, i.e. NGOs engaged in providing support to vulnerable populations. Section 6.1 presents the findings from the survey and the Section 6.2 is a discussion of the results in the context of the literature including the desk review. Knowledge sought at this level, provides insight onto the practices and actions made by organisations (actual reality) as well as existing knowledge related to IYCF (Figure 3-2).

Section 6.1 Results – IYCF-E Policies and Programmatic Activities at the Organisational

6.1.1 Response rate.

Out of the 135 NGOs that were sent the invitation and questionnaire, 11 (8%) failed to be delivered (incorrect email addresses). Therefore, it is assumed that 124 NGOs received the correspondence. Of these, nine (7%) said the questionnaire was not applicable to their work, one (1%) refused to respond and 54 (44%) provided responses.

Responses were received in batches. The first email request and two reminders were sent between December 2014 and January 2015. Initially 10 responses were received. After the first reminder, 19 responses were received, after the second reminder 15

were received and a further 10 were received after a third reminder (sent during July 2014[17]).

Table 6-1 Summary of responses to NGO questionnaire

	Local NGOs	*INGOs*	*Total*	*Percentage*
Email sent	82	53	135	
Delivery failure	9	2	11	
Email received	73	51	124	100%
Responded to the questionnaire				
Responded N/A	*3*	*6*	*9*	*7%*
Refused to respond	*1*	*0*	*1*	*1%*
Responded with data	25	29	54	44%
Did not respond	44	16	60	48%

Fifty-three (53) organisations answered online in English and one organisation answered in Arabic. One INGO answered online and also sent the questionnaire by email. When compared, the answers were identical.

One organisation answered twice, once in August and another time in December 2014. When compared, the answers were different. For example, the first time the organisation indicated working only at a local level. Also, the first set of answers included a lot of 'not applicable' whereas the second set had questions answered. The second set of answers was included because these matched the information on the

[17] The researcher was on maternity leave between August and November 2014.

organisation's website and a valid email address for the person answering the questionnaire was provided. Table 6-1 is a summary of the responses from NGOs.

6.1.2 Description of organisations responding to the questionnaire.

Of the 54 organisations, 29 (54%) were International Non-Governmental Organisations (INGO) and 25 (46%) Local Non-Governmental Organisations (LNGO). The INGO organisations were more likely to respond (57%) compared to local (34%)

One organisation reported being 'intergovernmental', however, for ease of categorisation and given that the organisation is international according to its website, it was counted as an INGO. Also, one organisation reported being an international non-profit organisation ('INPO') but was also categorised as INGO as both names are given to INGOs. One organisation that also filled out the questionnaire by email reported being both international and national. After referring to the organisation's website and confirming its nature, it was categorised as INGO. Another organisation reported being a UN agency and after referring to its website, the latter turned out to be a local organisation and therefore was counted as LNGO.

The 54 organisations were divided based on their area of operations: 28 (52%) reported working at the national level, 14 (26%) reported working in more than one geographic region and 12 (22%) reported working only in one geographic region. Figure 6-1 shows the number of NGOs that work in each of the regions.

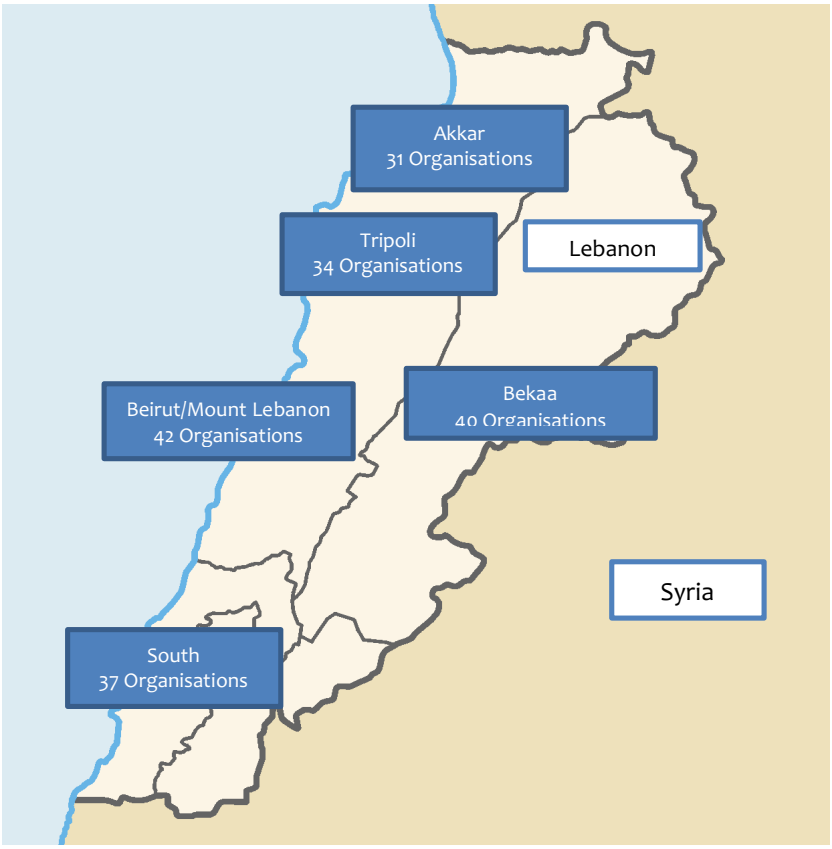

Figure 6-1 Map of Lebanon

6.1.3 Infant and young child feeding policies.

Out of the 54 NGOs, eight (15%) responded that they had a written policy on IYCF within their own organisation. Five were international organisations and three were local organisations. The remaining did not have an internal policy (20 INGOs and 21 LNGOs) or didn't know (4 INGOs and 1 LNGO) (Table 6-2).

When asked about willingness to share the policy, four organisations said they were willing to share this (Table 6-2). The four organisations (3 INGOs and one LNGO) that answered having a policy and were willing to share were sent an email requesting a copy. One sent the policy and indicated that it was still a draft, another confirmed having a policy but needed to double check willingness to share with a technical

supervisor, and a third indicated that it was working on a policy but didn't actually have it ready yet, and the local NGO did not answer the inquiry. In summary, only one policy was actually available for inspection and it was in draft format.

In terms of endorsing an external written policy on IYCF, 53 organisations answered the question of which 12 (23%) answered 'yes' (8 INGOs and 4 LNGOs). The remaining answered 'no' (26) or 'I don't know' (15). Of these 12, five (three INGOs - and two LNGOs) were the same as those who indicated having an internal policy (Table 6-2).

When asked to indicate the name of the policy that they endorsed, 13 organisations answered the question (7 INGOs and 6 lNGOs). Of these 13, eleven had answered 'yes' to the question on endorsing an external policy and the remaining two had not indicated endorsing an external policy yet went ahead and answered this question. One organisation that had answered endorsing an external policy did not answer the question on the name of the policy.

Of the 13 organisations that answered this question, some mentioned more than one policy. Six mentioned existing policies and guidance, the rest had incomplete answers[18] as shown in Table 6-2 below. In summary, the policies and guidance reported were:

[18] Incomplete answers were answers that did not name the title of the policy.

- "IYCF in Emergencies - IFE Core Group" – referring to the Operational Guidance on Infant and Young Child Feeding in Emergencies by the Infant Feeding in Emergencies Core Group.
- "SPHERE standards" – referring to the Sphere Project, Humanitarian Charter and Standards (Greaney et al., 2011).
- "WHO International Code of Marketing of Breast Milk Substitutes" (WHO, 1981)
- "WHA 34.22"- referring to the World Health Assembly resolution number 34.22: International Code of Marketing of Breast Milk Substitutes.
- "IASC[19] Core Commitments for Children in Emergencies" – referring to the Interagency Standing Committee Core Commitments for Children in Emergencies.
- "Statement 47 of the Lebanese law" – referring to the Lebanese Law 47/2008

Therefore, only 11 (20%) organisations either had their own policy (n=5), endorsed a valid external policy on IYCF (n=3), or both (n=3) (Table 6-2).

[19] Inter-Agency Standing Committee

Table 6-2 Summary of NGO answers related to IYCF policy

NGO#	Have a written policy?	Willingness to share policy	Endorse external policy?	Type of external policy*
LNGO-02	No	Not Applicable – No written policy on IYCF	Yes	The policy issued by [name of INGO-40]
INGO-03	No	Not Applicable – No written policy on IYCF	Yes	Ministry of Public Health policies as well as those of specialised organizations
INGO-10	No	Not Applicable – No written policy on IYCF	Yes	IYCF in Emergencies - IFE Core Group; SPHERE standards; International Code of Marketing of Breast Milk Substitutes; IASC Core Commitments for Children in Emergencies;
INGO-13	No	Not Applicable – No written policy on IYCF	Yes	WHO International Code of Marketing of Breast Milk Substitutes
INGO-18	No	Not Applicable – No written policy on IYCF	Yes	the latest one
INGO-19	Yes	No	Yes	[name of INGO-19]
INGO-28	Yes	No	I don't know	
INGO-29	Yes	Yes	Yes	The International Code of Marketing of Breast milk Substitutes' endorsed by the World Health Assembly (WHA) in 1981 (WHA 34.22) - Statement number 47 of the Lebanese law to prevent milk substitute usage and promotion in all public hospitals and health care facilities, MoPH 1993 and 2011

NGO#	Have a written policy?	Willingness to share policy	Endorse external policy?	Type of external policy*
INGO-32	No	Yes	I don't know	
INGO-40	Yes	Yes	Yes	Law 47/2008, The International Code of Marketing of Breast Milk Substitutes, Joint Statement on Infant and Young Child Feeding in Emergencies
INGO-41	I don't know	Yes	I don't know	
LNGO-44	Yes	Not Applicable – No written policy on IYCF	I don't know	WHO
INGO-45	Yes	Yes	No	
LNGO-47	Yes	Yes	Yes	'protaction'[20]
INGO-51	No	Not Applicable – No written policy on IYCF	Yes	
LNGO-52	No	Not Applicable – No written policy on IYCF	Yes	SPHERE Handbook
LNGO-53	No	No	No	
LNGO-54	Yes	No	Yes	The International Code of Marketing of Breast Milk Substitutes

*As written in the questionnaire by the respondents

[20] As shown in the questionnaire. It is assumed that the respondent meant 'protection'.

6.1.3 Infant and young child feeding programmatic activities.

The organisations' basic activities varied, extending from provision of non-food items (kitchen utensils, beddings, diapers, etc.) to school education and health care (including nutrition and food security) (Table 6-3).

*Table 6-3 Type of activity**

Types of activity in which the 54 organisations were engaged		
	N=	%
Distribution of non-food items	32	59%
Health - General	21	39%
WASH[21]	18	33%
Education	18	33%
Health - Reproductive health	17	32%
Distribution of food items	16	30%
Food security and livelihood	12	22%
Health - Nutrition	11	20%
Protection	3	6%
Other	17	32%

*The types of activities are based on the sectors listed under the Sphere project (Greaney et al., 2011).

[21] Water Sanitation and Hygiene Promotion.

Thirty organisations reported implementing programmes targeting infants and young children (18 INGOs and 12 LNGOs) out of which three LNGOs also indicated having a policy on IYCF, and six INGOs and four LNGOs indicated endorsing an external policy.

The majority of organisations that reported having a programme targeting infants and young children were engaged in health awareness activities (25 NGOs). Most (22) were also engaged in support for primary health. Almost half were engaged in capacity building activities (trainings) and distribution of relief items (Table 6-4).

Table 6-4 NGO activities targeting infants and young children (n=30)

Type of activity	NGOs (*n*)	%
Distribution of relief items	14	26%
Capacity building	15	28%
Protection	1	2%
Livelihood	1	2%
Health awareness	25	46%
Hygiene promotion	1	2%
Support for primary health	22	41%
Health care	3	6%

When asked about the objectives of these activities, 23 organisations replied and provided a brief description. Out of these, 18 had objectives related to health or IYCF. These were coded into four categories (Table 6-5).

Table 6-5 Coding of NGO programme objectives

Coding of programme objectives	
International Non-Governmental Organisation (INGO)	
Category 1: Health promotion	7
Category 2: IYCF promotion	1
Category 3: IYCF promotion, support	2
Category 4: IYCF promotion, support, protection	3
National or Local Non-Governmental Organisation (LNGO)	
Category 1: Health promotion	0
Category 2: IYCF promotion	2
Category 3: IYCF promotion, support	2
Category 4: IYCF promotion, support, protection	1
Total	**18**

Eighteen INGOs and one LNGO reported having a system or programme designed to protect, promote, and support infant and young child feeding. The rest either did not (18 INGOs and 14 LNGOs) or answered 'I don't know (3 LNGOs). However, in reality, based on reported objectives, and as per Table 6-5, only four organisations had objectives that indicate this.

6.1.4 Donations and distribution of infant formula and milk.

Three LNGOs working in Bekaa (LNGO-01, LNGO-47) and Beirut and Mount Lebanon (LNGO-35) reported receiving donations of infant formula from an external source while two LNGOs indicated they did not know whether their organisation ever received such a donation. None of the organizations reported discarding the donation and none reported on the quantity received. All three reported distribution of the

donated formula ‘to infants within the general distribution’ (LNGO-35, LNGO-01, LNGO-47), and ‘to families of non-breastfed infants’ (LNGO-01, LNGO-47). LNGO-47 added also ‘donating to MoPH’.

Regardless of whether organisations received donations, five indicated distributing infant formula (three of which were the same NGOs as those receiving donations). One LNGO answered they didn’t know whether their organisation distributed any infant formula to families. The two organisations that did not receive infant formula distributed to selected mothers and infants; the rest used mass distribution. Tables 6-6 and 6-7 show a summary of responses received from the five organisations that indicated distributing infant formula.

The tables describe the nature of the activities that these five organisations were engaged in as well as the extent to which the distribution of infant formula was in line with IYCF-E policies and guidance.

6.1.5 Conclusion

In summary, few organisations either had their own policy, endorsed a valid external policy on IYCF or both. Only four organisation had a programme with objectives encompassing the three pillars of promotion, support, and protection. One of those organisations was distributing infant formula in compliance with IYCF-E policies and guidance.

Table 6-6 Programmatic activities and policy status of organisations engaged in provision of infant formula

	LNGO-01	INGO-33	LNGO-35	INGO-40	LNGO-47
Geographical coverage	One region	National	Two regions	National	One region
PROGRAMMATIC ACTIVITIES					
Distribution of food items	Y	-	Y	Y	Y
Distribution of non-food items	Y	-	Y	Y	-
Reproductive health	Y	Y	-	Y	-
Health	Y	Y	-	Y	-
Food Security and Livelihood	Y	-	-	Y	Y
Education	Y	-	Y	Y	Y
Nutrition	-	-	-	Y	-
WASH	-	-	-	Y	Y
Organisation targets PLWs and IYC[22]	Y	Y	Y	Y	Y
Activities targeting PLWs[23] and IYC					
Distribution of relief items	Y	-	-	Y	Y
Support for primary health	Y	Y	-	Y	Y
Health awareness	Y	Y	-	Y	Y
Capacity building	-	-	Y	Y	Y
Organisation reports having a system for promotion, support and protection of IYCF	DNK	N Not aligned	N Not aligned	Y Aligned	N Not aligned
Evaluation of program objectives					
Program objectives include IYCF promotion	N Not aligned	N Not aligned	N Not aligned	Y Aligned	N Not aligned
Program objectives include IYCF support	N Not aligned	N Not aligned	N Not aligned	Y Aligned	N Not aligned
Program objectives include IYCF protection	N Not aligned	N Not aligned	N Not aligned	Y Aligned	N Not aligned
POLICY STATUS					
Organisation has a written IYCF policy?	N Not aligned	N Not aligned	N Not aligned	Y Aligned	Y Aligned
IYCF policy shared?	N/A	N/A	N/A	Y Aligned	N
Organisation endorses an external IYCF policy?	N Not aligned	N Not aligned	N Not aligned	Y Aligned	Y Aligned
Organisation endorses a valid external policy?	N/A	N/A	N/A	Y Aligned	N Not aligned

Y = Yes
N= No
N/A = Not applicable
Aligned = Aligned with IYCF-E guidance
Not aligned = Not aligned with IYCF-E guidance
DNK = Does not know

[22] IYC = Infants and young children (less than two years of age)
[23] PLWs = Pregnant and lactating women

Table 6-7 Mode of provision of infant formula amongst five organisations engaged in provision of infant formula

	LNGO-01	INGO-33	LNGO-35	LNGO-40	LNGO-47
HANDLING OF BREAST MILK SUBSTITUTES					
Receipt of donation					
Organisation received donation of infant formula?	Y Not aligned	N Aligned	Y Not aligned	N Aligned	Y Not aligned
Quantity of donation	N/I	N/A	N/I	N/A	N/I
Mode of distribution of donation					
Mass/blanket distribution	Y Not aligned	N/A	Y Not aligned	N/A	Y Not aligned
Targeted distribution	Y Aligned	N/A	N	N/A	Y Aligned*
Distribution of infant formula					
Organisation engaged in distribution of infant formula?	Y	Y	Y	Y	Y
Organisation is currently distributing infant formula?	Y	Y	N	Y	N
Duration expected to continue distribution?	N/I	4 years	N/A	Depends on funding	N/A
Mode of distribution of infant formula					
Mass/blanket distribution	Y Not aligned	Y Not aligned	N Aligned	N Aligned	Y Not aligned
Targeted distribution	N	N	Y Aligned	Y Aligned	N
#of families/infants benefiting from infant formula	3500	2000	675	60	N/A
# of times in the last 6 months	N/I	2x	1x	N/I	N/I
Organisation assessed infants prior to provision of infant formula?	Y Aligned	N Not aligned	N Not aligned	Y Aligned	Y Aligned
Infant formula was purchased?	N Not aligned	Y Aligned	Y Aligned	Y Aligned	N Not aligned
Infant formula was donated?	Y Not aligned	N Aligned	Y Not aligned	N Aligned	Y Not aligned
# of cans distributed?	N/I	N/I	N/I	1600	N/I
Infant formula labelled in Arabic?	Y Aligned	Y Aligned	Y Aligned	Y Aligned	N Not aligned
Brand name of infant formula displayed?	Y Not aligned	Y Not aligned	Y Not aligned	N Aligned	N Aligned
Distribution of milk powder					
Organisation distributed powdered milk (cow milk)	Y Not aligned	N Aligned	Y Not aligned	N Aligned	N Aligned
# of families targeted?	1100	N/A	1320	N/A	N/A
# of distributions in the last 6 months?	78x	N/A	2x	N/A	N/A
VIOLATIONS TO IYCF POLICY					
Organisation in violation of the Code / Law 47/2008 / Joint Statement based on above activities?	**Y**	**Y**	**Y**	**N**	**Y**

Section 6.2 Discussion of Findings at the Organisational Level

This part of the research examined the Case (IYCF-E policies and programmatic activities) at the organisational level through the administration of a survey questionnaire and the document review. This is the first study to examine IYCF policies and programmatic activities within local and international organisations active in Lebanon during the current response to the Syrian crisis. Findings show that despite the diversity of interventions, IYCF programming and policies are still limited to very few organisations.

The response rate of 52% was encouraging because a previous study undertaken in 2006 achieved data from only 28 NGOs (25% response rate in Obeid (2006)). However, the process for data collection was challenging and time consuming (three reminders) and reflects the dynamism of the situation and the current workload for emergency agencies. This may be due to the heavy workload that organisations are engaged in during the refugee response. International organisations were more likely to respond to the survey, which may reflect greater experience with research participation and/or greater overall capacity. In fact, according to a mapping of NGOs in Lebanon, most local organisations have less than 10 employees and have a high reliance on part-time employees (Civil Society Facility South [CSFS], 2015). Almost half the organisations worked at the national level; the rest worked in several localities with very few being operational in only one area. The diversity of interventions is striking, with most organisations engaged in at least three or four kinds of activities, of which IYCF is just one.

6.2.1 Policies and programmatic activities.

The first recommendation in the OG-IYCF-E is for organisations to have an established internal policy on IYCF as a preparedness measure (IFE Core Group, 2007). In terms of existing policies on IYCF, very few organisations had an internal written IYCF policy and for some organisations, there seemed to be a lack of clarity about whether a policy existed. Based on the desk review conducted, at least for one surveyed organisation, an internal IYCF policy did in fact exist at the headquarters level, but this was not reflected in this organisation's answers. This discrepancy in the answers could be related to respondents' knowledge which may not have fully represented the organisation's policies and activities. Whilst it was requested that the survey was completed by appropriate staff it is possible that respondents may have not been familiar with existing organisational IYCF policies. MacLaine & Corbett (2006) reported that INGO staff, questioned about their organisation's policy on infant feeding in emergencies, did not report awareness of the policy or its details. Also, the lack of policy and institutionalisation of general systems was reported specifically for local NGOs in Lebanon where only 17% of surveyed NGOs had such systems put in place (CSFS, 2015).

For a few organisations there was some lack of clarity about whether they had a written IYCF policy or not. Within questions related to endorsing or having a policy there were apparent contradictions in the answers between questions that were purely objective

(yes and no answers) and questions that required an elaboration (such as naming or sharing the policy). This is also valid for questions related to programming on IYCF.

Very few organisations endorsed a valid international or local policy. Lebanon has endorsed the Code through Law 47/2008 which regulates the marketing of BMS (RoL, 2008; IBFAN, 2015); however, only one NGO actually cited this law. The rest named international guidance with the Code being the most commonly cited. In addition, a joint statement on IYCF was issued in 2012 that includes guidance on IYCF in the current crisis (MoPH et al., 2012). Only one NGO – the one that helped facilitate the issuing of the statement – mentioned this. Another referred to the statement as "the one issued by [name of the organisation]". The fact that only one organisation representative was aware of the local Lebanese Law indicates the need to further increase awareness of the law amongst organisations. MacLaine & Corbett (2006) also reported that INGO staff in Lebanon, questioned about their organisation's policy on infant feeding in emergencies, did not report awareness of the policy or its details.

Findings also indicate that organisations or respondents may not have been aware of some terminologies including what a policy is, or may have not linked the Law to being a policy that is written for NGOs. Within questions related to endorsing or having a policy there were apparent contradictions in the answers between questions that were purely objective (yes and no answers) and questions that required an elaboration (such as

naming or sharing the policy). This is also valid for questions related to programming on IYCF.

In terms of programmes, and despite a considerable number of organisations working in health and targeting pregnant and lactating women and infants and young children, few organisations were able to integrate a comprehensive IYCF-E programme. IYCF programmes have been reported to be most effective when integrated alongside other interventions such as maternal and child health (Save the Children & UNHCR, 2015; UNICEF, 2011). A multi-sectorial approach that integrates nutrition with other sectors such as health creates efficiencies and is currently promoted by various movements in the field of nutrition (Duggan, 2014; GNC, 2014; Save the Children & UNHCR, 2015). It was apparent that the organisations' understanding of promoting, supporting, and protecting IYCF was not clear. While many indicated that they had such a system, analysis of their programme objectives showed that their activities did not cover all three pillars. Most of the activities focused on promotion such as provision of awareness and very few included support such as counselling or protection including working on enforcing IYCF policies. The implementation of IYCF programmes during emergencies requires human resources and sets of skills and competencies to ensure provision of counselling and support (Meeker et al., 2014). It may be that such capacities and resources may not have been available within organisations. Alternatively, organisations may not have prioritised such an intervention despite the evidenced contribution of IYCF interventions to decreasing child mortality and morbidity (Victora et al., 2016).

6.2.2 Distribution of infant formula.

In terms of distribution and receipt of donations of artificial formula, few organisations reported receiving donations of infant formula all of which were LNGOs working in well-defined areas. Compared to emergencies elsewhere, it seems the amount of infant formula reported to be donated was less. For example, in the Balkans, Borrel et al. (2001) documented that, in the early days around 3,500 metric tons of humanitarian aid was donated, of which an estimated 40% was baby food. More recently in Syria, one of the largest humanitarian organisations in Damascus received a donation of 40 metric tons including baby milk (Syrian Arab Red Crescent, 2015). Although in this study NGOs did not specify the amounts of donations received, the number of families receiving donated infant formula was relatively small, which might indicate that the quantity received was low.

Most organisations that dealt with infant formula, did so in violation of the Code and the national Law. Article 6.2 of the OG-IYCF-E, the Joint Statement and Law 47/2008 all clarify that there should be clear criteria for targeting and use of BMS. Of the five organisations that handled BMS, only one was consistent in targeting selected mothers and infants (as opposed to untargeted blanket donations) and only 60 infants were targeted. The rest distributed to more than 3,500 families. Most of the organisations distributed infant formula that is branded and labelled in Arabic except for one that violated the guidance. It is therefore evident that even with national policies and statements in place, these were

not completely implemented or reflected in the work being undertaken. This is consistent with the findings of Borrel et al.'s (2001) Balkans study which identified a lack of translation from policy to practice due in part to weak institutionalisation of policies, the absence of monitoring systems, and inadequate coordination mechanisms.

In Lebanon in 2006, MacLaine (2006) reported similar findings indicating violations of the Code and the OG-IYCF-E. In that study, infant formula was distributed within baby kits by at least one INGO and three LNGOs and around 1,500 baby kits were distributed (MacLaine). The magnitude of the violations is therefore still similar nine years after the last emergency in 2006. However, it is also worth noting that the current refugee crisis is much greater than the 2006 emergency in Lebanon, with many more people affected (UNHCR, 2017).

Compared to other crises, the violations may be considered limited where thousands have been reported to receive untargeted infant formula; in the case of Lebanon, this constitutes less than 1% of the affected population (UNHCR, 2017). In Jakarta for example and after the earthquake, Hipgrave et al. (2012) showed that 80% of affected families received infant formula. Similarly, in Iraq during the 2003 war, BMS were included in the food basket, which affected mothers' decision to breastfeed (International Study Team, 2003). It is worth noting however that the design of the studies was different in terms of reporting on violations since the current study collected information directly from organisations through an online survey whereas most other studies looked at violations

through surveys with mothers and health care providers (McInnes, Wright, Haq, & McGranachan, 2007). For example, Aguayo, Ross, Kanon, and Ouedraogo (2003) reported on violations in West Africa through a survey with health facilities and distribution points. Similarly, MacLaine (2006) communicated with mothers, health care providers and NGO workers on distribution of infant formula to affected populations. Sometimes direct observations are also adopted such as in China where Liu, Dai, Xie, and Chen (2014) included observation as part of their data collection methods. Therefore, one might argue that violations may be under-reported by organisations, whereas observations and reporting from beneficiaries allow for a more valid data collection method. Chapter 7 includes findings from focus groups with HCPs and mothers which confirm findings of the limited distribution of infant formula.

At the same time, the limited support for non-breastfed infants is important to address. Findings show that only one NGO targeted families with artificial feeding support in line with recommendations (60 families were involved). The World Food Program (UNHCR et al., 2016) reported that 45% of infants are exclusively breastfed amongst the Syrian refugee population in Lebanon, highlighting a high percentage of non-breastfed infants in need of support. Previously, Dolan, McGrath, and Shoham (2015) reported on IYCF interventions during the current response in Lebanon and other countries and claimed that interventions in nutrition in Lebanon “missed the point”. Dolan et al. (2015) noted that few interventions focused on breastfeeding but also that the needs of non-breastfed infants were not met through targeted artificial feeding support.

Overall, the limited IYCF activities and lack of policies indicate a need to upscale action to respond to the needs of infants and young children. Despite the large pool of organisations that may be expected to work on IYCF, very few had programmes established. The concept of championing has been discussed in different situations where it has been linked to the success of national initiatives and has been included in recommendations for advocating nutritional and IYCF initiatives (Ashworth & Jackson, 2011; Kathumba, 2012; Sumner, Lindstrom, & Haddad, 2008). It could be that the presence of such a champion in Lebanon would contribute to improving policies and programmatic activities on IYCF. Findings at the central level show that there is potentially at least one organisation that is dedicated to upholding IYCF and there is potential that such organisations might play a role in improving IYCF interventions.

6.2.3 Conclusion.

The current findings show, that despite the large number of organisations targeting infants and young children, IYCF-E is not being given priority within organisational programming. Very few organisations had established policies related to IYCF in the current refugee crisis in Lebanon. IYCF interventions were limited to promotion of breastfeeding but not support or protection for breastfeeding mothers. Violations to national and international guidance occurred mainly in local organisations and IYCF was rarely integrated within programmes despite the fact that many organisations target PLWs and infants and young children.

In order to improve response during the current refugee crisis in Lebanon, and given the importance of ensuring adherence to recommended IYCF practices during emergencies, there is a need to ensure that policies are implemented at the central level within organisations, that they guide everyday practice and that interventions support, promote, and protect IYCF.

Chapter 7 IYCF-E POLICIES AND PROGRAMMATIC ACTIVITIES: FINDINGS AT THE SERVICE PROVISION LEVEL

This chapter explores the Case at the service provision level. It includes three sections; Section 7.1 presents findings from focus groups with HCPs, Section 7.2 findings from focus groups with mothers, and Section 7.3 is a discussion of these findings in the context of the literature including the desk review. Knowledge sought at this level provides insight onto the perceived reality as perceived by HCPs and mothers as well as the actual reality as experienced by mothers (Figure 3-2).

Section 7.1 Results from Focus Groups with Health Care Providers

Eight focus groups were conducted with 51 providers of primary health care including nurses, midwives, and doctors involved in the provision of health services in PHCCs. Focus groups were conducted between April and June of 2015. Table 7-1 below is a description of the participants in the focus groups.

Table 7-1 Participants in the focus groups with health care providers

Participants	SOUTH	BEIRUT/ MOUNT LEBANON	NORTH	BEKAA	TOTAL
Nurse	3	6	4	3	**16**
Director of Primary Health Care Centre	2	1	2	1	**6**
Health assistant[24]	4	0	1	1	**6**
Social and health worker	2	4	0	0	**6**
NGO Field officer	1	2	1	1	**5**
Doctor	0	1	1	1	**3**
Administrative assistant	0	1	0	2	**3**
Laboratory technician	0	2	1	0	**2**
Midwife[25]	1	0	0	1	**3**
Physiotherapist	1	0	0	0	**1**
Total	**14**	**17**	**10**	**10**	**51**

Two focus groups were conducted with HCPs in each of the four main regions in Lebanon; i) Beirut/Mount Lebanon, ii) North, iii) Bekaa, and iv) South. The purpose of the focus groups was to explore their views on existing programmatic activities related to IYCF in emergencies, examine the extent to which activities are aligned with existing policies and

[24] Health assistants usually have a health background but do not have a nursing diploma. One of the health assistants held also the position of "health promoter (including mental health)" and another held the additional position of "screening assistant" working with an NGO supporting the centre.

[25] One of the midwives also held the position of "lactation specialist" working with an NGO supporting the centre.

guidelines and to investigate perceived barriers and opportunities for implementation of policies and programmes in support of IYCF in emergencies. Focus groups were conducted in colloquial Arabic/Lebanese and all conversations were in Arabic. On average each focus group discussion took around 45 minutes. Discussions were recorded and transcribed in Arabic and then translated into English by the researcher as described in Chapter 3, Section 3.3 'Methods'. Transcripts were analysed using a thematic approach and a verification process was adopted also described in Chapter 3. Section 3.4 'Analysis'.

7.1.1 IYCF and IYCF-E policies, programmatic activities, and capacity.

7.1.1a Existing institutional IYCF and IYCF-E policies – policies not documented but mostly practiced.

Participants were asked about their awareness of existing institutional policies related to IYCF or IYCF-E. Some staff responded that such a written policy did not exist. Most participants indicated not having any written policies specific to the centre that they could discuss (and share).

> *Interviewer: "Are there any written policies or a written program?"*
>
> *Nurse: "No, about breastfeeding no".*
>
> *Midwife: "Now, since we are a primary health centre then our policy is taken from that of the Ministry [MoPH]" (FG526)*
>
> *Interviewer: Are you aware … of specific policies or laws in Lebanon … that are related to IYCF?*

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[26] FG# indicates the focus group number. For example, FG5 is the fifth conducted focus group.

Nurse: "No, I've no idea and have not heard of it" (FG6)

Interviewer: "Is there a written policy or law that exists?"

PHCC director: "No no … I mean as Ministry [MoPH], I don't know if there is [a law], I did not get any instructions from the Ministry about this… to do 1, 2, 3, …. You mean a policy from the Ministry?

Interviewer: "Yes, but also if you have a particular institutional policy'

PHCC director: "No …"

Interviewer: "About breastfeeding?"

PHCC director: "No no … only education" (FG7)

They indicated that no verbal instructions were given from MoPH regarding IYCF or IYCF-E. Others were uncertain about the existence of any policies at the institutional and / or the national level. Some mentioned that IYCF is not a priority for MoPH since there is no law.

Interviewer: "Do you think IYCF is a priority?"

Two to three HCPs together: "Yes sure sure"

Interviewer: "Did the Ministry put IYCF as a priority?"

Same HCPs together: "No no no"

HCP: "Let them put a law at least" (FG2)

In other cases, participants did refer to existing institutional or national policies, however these were not accessible in written format. The policies that were cited included MoPH policy, instructions from the primary health department at MoPH, the joint statement on IYCF-E which was referred to as "the policy shared by [name of a supporting international organisation]", and the BFHI. When elaborating on the content of policies, staff described the content as guidance on distribution of infant formula and support for breastfeeding.

HCP: "I know particular policies but I don't know if they are part of a law, it is a policy that says that the primary health care centres are part of the MoPH with the Baby-Friendly Hospitals, … it is forbidden to have anything other than breastfeeding…it is forbidden to put brochures that have to do with a milk bottle and to put a can of milk in the centre and prescribe a certain brand of milk" (FG3).

For most centres, staff recited standards of practice that they abide by despite the lack of written policies. Those consisted of a routine whereby no infant formula should be provided to mothers through the centres. Only mothers who are not breastfeeding for medical reasons would be supported with artificial feeding, but these need to obtain the formula from outside the centre.

HCP: "There are many who would come to ask me, is there milk? I tell them, this is a primary health care centre, it is absolutely forbidden for milk to enter[27] [the PHCC]." (FG3)

In addition, the requirement of supporting and promoting breastfeeding "only" until the age of six months was mentioned within the standard of practice.

Standards of practice were linked to capacity building training received or information from professional training. HCPs mentioned receiving capacity building and training by MoPH and UNICEF on IYCF.

Interviewer: "Ok, so this practice, where did it come from… you have this conviction… who told you to do this?"

[27] By "enter" the participants mean: to be available at the centre or be present at the centre.

HCP: "It is coming from the trainings that we have done… because we have been trained on this programme and our work has a big part of this, so naturally…" (FG4)

In a few instances, staff referred to the educational material such as posters and flyers as the standards by which they abide.

HCP: "During pregnancy, we inform the pregnant lady and tell her about the importance of breastfeeding, this policy is taken from the Ministry and we have guidance in the brochures …"

Interviewer: "You mentioned a policy from the Ministry, have you seen this policy? do you have a copy?"

HCP: "The Ministry [MoPH] has a copy? …. Err I am not sure…. it exists… I don't know..."

PHCC director: "There are brochures on the door outside" (FG5).

Participants were asked about the extent to which they perceived existing IYCF and IYCF-E policies are implemented and in almost all of the centres, staff confirmed that MoPH forbids distribution of infant formula and supports breastfeeding. Participants also indicated being informed by MoPH that based on their policy, if they see any violation related to distribution of infant formula, they should report it to MoPH. Some mentioned IYCF policies might not have been implemented before but there is a perception they are better implemented now.

Participants gave examples of some violations mainly related to doctors where the latter were advised by centre staff about the policy.

PHCC director: "For your info we received offers from milk companies… they said whatever you want, just put a stand… or a brochure with the logo of this milk… you put the price…"

HCP: "We follow the policy of the Ministry and we are a PHCC" (FG3).

HCP: "Because we used to have samples …. they used to bring specifically for Syrians since we started with Syrians… several representatives came and gave to the doctors…. and left them here…. once they left we told the doctors take them… take them to your clinics…why? because we are convinced that a mother should breastfeed…" (FG4)

Participants also gave examples that demonstrate that IYCF policies are being implemented and they highlighted how the centre administration contributed to this enforcement.

HCP: "For us, we were able to … prevent the inclusion of any milk in the food parcels. We took the recommendation and shared it … within the protocol of the UN and [name of organisation] with UNICEF ……this milk is forbidden to be included in the food ration because the mother will give the milk and she will stop breastfeeding … for me, when I have one or two exceptions [mothers not breastfeeding], I do not harm 90 or 91 mothers [who are breastfeeding]." (FG8)

In summary, although IYCF or IYCF-E policies are not well documented within PHCCs, standards of practice or routine practices do exist. At the same time, the extent of implementation of existing policies varies from one centre to another.

7.1.1b Existing IYCF services and activities revolve around education.

HCPs were asked about the services targeting pregnant and lactating women and aiming to support IYCF. The services mentioned included first and foremost education and awareness in the form of sessions for a group of mothers. Participants in almost all centres indicated providing education sessions for mothers on a number of related topics including importance of breastfeeding and addressing misconceptions related to IYCF. These were described as classes that mothers attend in the centre which are administered by a professional, be it a lactation specialist, a midwife or a doctor. The frequency of providing such a service varied between centres. Staff in some centres indicated conducting sessions administered by HCPs from within the centres and on a regular basis, others relied on supporting organisations, while some mentioned conducting sessions on an ad hoc basis depending on availability of a doctor or specialist. One centre mentioned awareness about vaccination with IYCF.

> *Health assistant: "As activities, we have an awareness program… nothing else…. for the mothers" (FG7)*
>
> *Nurse: "We provide sessions…. about pregnancy and everything related to breastfeeding and its benefit." (FG2)*

In addition to education and awareness, a few centres mentioned providing advice to mothers in the form of counselling. Counselling was described as provision of one-on-one support where mothers receive tailored advice related to breastfeeding. Counselling was not clearly mentioned as a separate service. It was often necessary to probe about opportunities when mothers are seen both at the pre-natal and post-natal phase and extent to which they were advised about breastfeeding or infant feeding.

HCP: "It is really not services, but we provide guidance before delivery…. guidance and if she comes after delivery, after one month or two months, if they have a problem with breastfeeding, we give enough counselling, something educational, one-on-one" (FG8).

For some centres, counselling was administered in an ad hoc fashion where existing staff such as a nurse or a midwife provided mothers with advice based on need. In describing this service, HCPs mentioned that they "speak with mothers" face to face to provide her with education and guidance before or after delivery. This would be done by the nurse in charge of immunisation or the midwife during a contact with the mother for other purposes such as vaccination or health assessment. For other centres, counselling was more organised and provided by a dedicated specialist who was especially allocated for this purpose. When such a specialist was mentioned, she would always be appointed and out-sourced by a supporting international or local organisation (NGO), and would visit the centre following a set schedule (for example weekly).

Midwife: "Yes, we have the organisation [name of organisation] …. this organization is specialised in breastfeeding, they have specialists and midwives and nutritionists. They follow this subject about the importance of breastfeeding and child nutrition and malnutrition." (FG5)

Although not fully organised, this service of providing advice to mothers was seen as valuable and even having more value than regular group education since it provides mothers with personalised guidance. Through this service, participants indicated that mothers who ask for infant formula are given guidance and advice that if the child is

growing properly there is no need for any infant formula. In addition, if a mother was pregnant, she is assured that she can breastfeed.

> *Midwife: "There are a lot of mothers who come and they want to give [supplement] milk …. No, we let them understand that the child is getting enough as long as he is growing and this child is growing and if he cries it would be because of something else, not necessary to give another milk" (FG2)*

Provision of counselling was also seen as an opportunity to provide mental health support to mothers. Some participants mentioned how providing one-on-one counselling is also an opportunity to show the mother that they care and that they are there for her.

Having a dedicated specialist was also seen by some as important and sometimes not enough to respond to the needs. In one centre, the director, when referring to the specialist, indicated the importance of her presence and the perception that the frequency of her visits might not be enough to meet the needs of the centre.

> *PHCC director: "We have a problem that we only have one person who comes for this service and it is normal to have shortage when she is allocated to several centres…."*
>
> *Nurse: "one lady alone for the area of the north... alone"*
>
> *PHCC director: "the issue is that she comes once a week and she sees all the cases …. she will not be able to give enough time to all mothers… especially that you have to speak about breastfeeding and how to breastfeed and you need to speak about hygiene and sterilisation and speak about those issues... of course when you have for two centres or three, one person… you need to have another [specialist] also…" (FG7)*

The value of counselling was also seen in the impact it had on mothers. Staff gave examples of how they affected the behaviour and practices of the mothers by providing

them with the necessary advice. Below is an example of how a mother was counselled to successfully re-lactate (i.e. re-start breastfeeding) after stopping breastfeeding.

> *Midwife: "There was a lady she had stopped breastfeeding for 10 days… and she says that her breast does not have [milk]… I told her, you need to try, you have to promise me, every hour, you give him, and you drink water, and drink milk… I started telling her about the food that she should eat… I told her, you are the base, if you put in your head that you want to breastfeed, water alone is enough to bring your milk… after one week, she came back… I had forgotten her, she said: "ask me", I said "what do you want me to ask you" I had forgotten about her… she said you told me about breastfeeding and I am now breastfeeding, no bottle no nothing… imagine after one week, her milk came back…" (FG3)*

In addition to education and counselling, provision of micronutrient supplements for pregnant and lactating mothers was mentioned by a number of participants. These were called maternity supplements and were perceived as useful to support maternal nutrition.

> *Nurse: "Vitamins, we give vitamins for nutrition… it is nutrition support for the mother and for the pregnant [woman]" (FG5)*

Participants in a few centres mentioned distribution of food kits and in one centre, it was reported that the activity was halted because the supply did not satisfy the needs.

> *HCP: "A long time ago… [we distributed] food rations… cleaning supplies…"*
>
> *Interviewer: "why did you stop giving these?"*
>
> *HCP: "No more support…"*
>
> *PHCC director: "We actually asked to stop… we said we don't want anymore…."*
>
> *Interviewer: "Why, you don't think it benefits?"*

PHCC director: "Let me tell you... there were problems …I mean I would have 300 rations and 5000 people come…. how are you going to respond? … I said, stop… find someone else to do this… let me be" (FG8)

In terms of providing access to infant formula through the centres, this was not explicitly specified as an activity. However, there were occasions where staff would raise this issue and mention that they would give infant formula. In most cases when provision of infant formula or milk was mentioned by one participant, the statement would then be followed up by explanation by another participant that the formula is provided to those mothers who are not breastfeeding, or that the action took place "before" and is no longer being executed. i.e. the statement would be 'corrected'.

Interviewer: "Do you as a centre provide milk?"

Health assistant: "We usually do campaigns"

Nurse: "Sometimes they come and they distribute milk"

Health assistant: "Sometimes they distribute milk meaning for those who have babies…" (FG6)

In addition to the above, management of malnutrition was also mentioned as a service provided by the centre and milk was included.

Health assistant: "As activities, we have an awareness program… nothing else…. for the mothers, we give them vitamins, also for the children based on their status…. if children have malnutrition we provide with a specific kind of milk" (FG7)

In a number of centres, participants indicated that IYCF activities were led and implemented with the support of an external organisation. These activities were administered within the centre and were dependent on the supporting organisation.

Participants mentioned more than one organisation supporting the centre in the area of maternal and child health. In one centre, participants highlighted the need for better coordination between the supporting organisation and the centre.

In summary, PHCCs provide few IYCF services targeting refugee pregnant and lactating women, focusing mainly on provision of awareness and education. Some centres also provide counselling and micronutrient supplementation on an-ad-hoc basis. In most of the centres, services related to IYCF were dependent on external assistance from a supportive organization.

7.1.1c Institutional capacity and existence of emergency preparedness plans.

Aside from existence of policies or programmes, participants were asked about emergency preparedness plans and the extent to which they perceive they and their centre are equipped to respond to IYCF needs during an emergency. In most centres participants reported receiving training and capacity building workshops on IYCF, however the perception of the level of preparedness for emergencies in what relates to IYCF varied between centres. In some centres, participants perceived being ready in case of an emergency situation and referred to staff being ready and committed to respond to emergencies. They gave examples of responses during the emergency in 2006 and regarded themselves as having good human resources and good capacity as a result of their training. Others reported that there wasn't much human capacity, referring to a lack of human resources and indicating the centre would not be ready.

Participants referred to training and capacity-building workshops on breastfeeding provided by MoPH or an external supporting organisation. However, the number and frequency of training sessions differed between centres where some centres received more training sessions than others.

Midwife: "MoPH does sessions, every now and then, they do trainings…. [name] from the primary health department…. we are given trainings[28]"

Nurse: "They do trainings" (FG5)

A number of participants referred to receiving capacity building support from international organisations on IYCF-E and related this to building their capacity and ability to respond to the needs of breastfeeding mothers. Some mentioned that their training as midwives includes the necessary information to equip them with the required knowledge.

HCP: "I just want to mention that this protocol [breastfeeding] is written within the activities of the legal midwife[29]" (FG8)

Preparedness and capacity of HCPs was also assessed using different scenarios presented to participants that include mothers presenting to the centre with certain challenges related to IYCF. When responding to these scenarios, and in one centre, participants were not able to respond adequately and recommended providing infant formula to all mothers.

[In response to a scenario of mother asking for milk in an emergency and extent to which it is easy to support breastfeeding]

Nurse: "Errr I honestly don't know…"

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[28] 'Trainings refer to training workshops or sessions.

[29] Legal Midwife is a term to refer to the midwife who has a license to practise midwifery.

Health assistant: "First that they are not able to secure milk … I don't have milk… the milk is not coming down…"

Interviewer: "How to support them?"

Health assistant: "Maybe someone can provide them with milk…. for example, they register their names with a social worker… they study their situation …" (FG6)

Others were able to provide elaborate feedback, for example, by confirming that the importance of breastfeeding is emphasised when a mother requests infant formula. Participants in one centre described how they would counsel mothers and discuss appropriate dietary intake. They linked the amount of food and the nature of the food she is eating with the ability to breastfeed. They also described how a mother's body prioritises the milk and removes nutrients from her body to ensure milk for the baby.

[In response to a scenario of a mother asking for milk and baby has diarrhoea]

Nurse: "First thing we tell her is that you need to continue breastfeeding"

HCP: "If there is milk"

Nurse: "But because there is diarrhoea - in case of diarrhoea he needs the breast …. for cleanliness and for immunity and many things…. so here we try in all ways to ensure that she continues breastfeeding…. from there on, we monitor …. that by God[30], one week, two weeks you have to try…" (FG3)

Participants were also asked about existence of emergency preparedness plans with emphasis on IYCF support. There were no written emergency preparedness plans specific to PHCCs mentioned in any of the focus groups. Emphasis was put on the presence of

[30] "By God" = This expression is common in sentences and means "truly" or "really".

external supporting organisations and that the centre would not be ready in case the supporting organisation phases out and stops its support. In one centre, participants indicated that due to the support of the external organisation, the administration was now thinking about having an IYCF strategy for responding to emergencies.

> *PHCC director: "For us, as a strategic plan for breastfeeding we do not have... honestly I mean, because [name of organisation] is here, because they are present, they are encouraging us to have a plan... or else we didn't know anything… they came and we found the operation useful and logical... the doctor was convinced and the staff was convinced and the people were convinced…now [name of the organisation] is here… the question is if [the organisation] leaves… no, we are not prepared… I tell you honestly... we are not ready" (FG5)*

In one centre, emergency preparedness activities were mentioned as part of the work of the municipality with the Lebanese Red Cross. Participants referred to the establishment of a committee within the community to work on emergency preparedness. However, IYCF was not included in this initiative.

Overall, PHCCs have received capacity-building training sessions for staff focusing on IYCF through MoPH and external organisations. There were varied perceptions about the level of preparedness of the centres in what relates to responding to emergencies; however, none of the centres indicated having written IYCF emergency preparedness plans.

7.1.2 Challenges in supporting IYCF.

Perceived challenges in supporting IYCF included those related to lack of professional and environmental support mainly due to lack of resources and conflict of interest. Mothers face a number of challenges that need support.

7.1.2a Barriers to appropriate IYCF related to provision of support.

While elaborating on existing services related to IYCF and IYCF-E and perceived needs to support IYCF in emergencies, HCPs highlighted several factors that hinder the provision of professional and adequate IYCF support for mothers.

Participants noted the lack of adequate staff or time to provide appropriate and sufficient guidance to mothers. Staff are overwhelmed with existing tasks which renders providing IYCF support difficult. This gap in provision of education and awareness was mentioned to be both at the primary health level and in hospitals and was related to both lack of time and capacity.

> *Health assistant: "I mean in [name of a private hospital] there is a lady who comes right after delivery to teach you how to breastfeed… other hospitals don't have that…. they put the baby and that is it… also sometimes there are people who don't say anything they come they give you the baby and 'bye bye'….or they come they tell you about breastfeeding and its benefit and I don't know what but they don't teach you… they give you a paper to read and of course you will not read it…" (FG6)*

Participants also reported instances when doctors provide inaccurate messages and advice to mothers that contradict counselling provided by other health staff such as nurses or midwives. Participants provided examples of instances when nurses would face

doctors who “do not support breastfeeding”. They elaborated further on challenges faced with doctors which they thought related to the provision of incentives from infant formula companies that negatively affect the quality of their counselling in supporting IYCF. It was reported that the marketing of infant formula is affecting the practice of HCPs including doctors. Participants reported that they perceive the Law is not being implemented; some doctors are seen promoting infant formula and are not able to provide adequate support for mothers as a result.

> *Nurse: “Sometimes the child would be one month and sometimes one week... they [doctors] go directly to artificial milk... one time I went directly to the doctor, I told him, please, if there is a case that you have that has something in particular with breastfeeding, please refer her to me.... don't refer her directly to artificial milk.... there are 20 to 30 cases that came into the same doctor and he’s given [them] milk” (FG7)*

Participants perceived that some doctors receive gifts from formula companies that they give to mothers and highlighted the dangers of such a practice where if mothers are given free samples, there is a problem in being able to sustain the milk supply. Staff also reported the challenge of receiving gifts of infant formula cans in hospitals which may sabotage breastfeeding.

> *HCP: “The doctors in general they are benefiting from the milk companies and travel trips and other trips and dinners and things like that…” (FG8)*

When such perceptions of doctors being influenced by formula companies were reported, doctors participating in the focus groups would exclude themselves and the reporting was usually done by nurses, other HCPs.

HCPs highlighted the lack of financial support from MoPH to be able to provide adequate IYCF services indicating gaps in support from the government. It was also reported that HCPs in PHCCs are not mandated to provide such a support especially if it was in the community.

> *Paediatric doctor: "It is a humanitarian problem… the nurse is oppressed … I am a doctor and I can be free to work as a volunteer… I am working, no one is obliging me… whereas the nurse… needs to live... she has her family…etc. at a time that there are no financial capabilities to conduct programs like they are saying … you need someone, a girl who would enter homes…. don't you want to send someone 10 days after to sit and teach the mother and encourage her to breastfeed? like in France and the US? where are you going to get her a salary? everything needs money…" (FG2)*

In one centre, participants also mentioned that there is no governing body to monitor the distribution of relief items and therefore to monitor the Law.

> *PHCC director: "Unfortunately here it is like a jungle… there is nothing called health monitoring, and there are institutions who are working through donors… be it local or Syrian… they come without going back to any official health or social reference… [not even the municipality]" (GFD8)*

7.1.2b Difficulties that mothers face.

In addition to the different barriers for providing adequate IYCF services during emergencies, participants pointed to a number of related issues faced by mothers. These included poor psychological health, poor nutrition, and other physical difficulties related to misconceptions and lack of knowledge.

The psychological state of the mothers and occurrence of post-partum depression were mentioned as factors affecting feeding practices and the need for support.

> *Nurse: "You feel that the majority… the woman, when she delivers she starts having depression after delivery… she immediately wants to care for her body… she forgets that she gave birth… some of them you feel they need support…" (FG3)*

The stress of being a refugee and living in different and difficult conditions were mentioned as factors hindering the provision of appropriate feeding including breastfeeding. The extent to which a mother was comfortable was seen as affecting their ability to provide appropriate feeding for their children.

> *HCP: "I mean, a woman if she gets rid of all her worries in order to breastfeed her son … still it is difficult... you understand… the problem that we are dealing with…. the stress… I mean, a woman would be sitting in her home, happy, and secure [and feel the stress] … now she is staying in a tent... or she came and sat in a place that is different …" (FG9)*

Participants spoke about the combination of different factors such as poor eating habits and nutritional status including anaemia as well as a lack of knowledge affecting IYCF practices. Multiple pregnancies, lack of child spacing and pregnancy at a younger age were often reported and elaborated upon as key in hindering the continuation of breastfeeding.

> *HCP: "[The woman/refugee] has a baby at the beginning of the year and another at the end of the year… the majority have low levels of calcium and anaemia… anaemia, I mean have you ever seen a haemoglobin of 6?" (FG9)*

HCP: "The main problems is that the mother is getting pregnant and her infant is one month or two months… we have so many they have these cases…. …. they are always pregnant" (FG4)

HCP: "I don't have the strength to breastfeed... in the first place... she has a state of fear... and the second thing, she tells you I am not able to eat… I mean, not eating and not able to carry the child…" (FG4)

There were some physical difficulties faced by mothers with breastfeeding that were reported as barriers to breastfeeding, such as inverted nipples. Participants also described common IYCF practices amongst refugee mothers. They indicated that Syrian refugees are committed to breastfeeding more than Lebanese mothers; they perceive breastfeeding as beneficial, but have also reported a number of inappropriate practices however including providing whole cow's milk to infants under six months of age.

Nurse: "I know a lot of mothers they bring "tatra[31]" milk and X kind of milk for children two months of age... even Lebanese… she would be three or four months and she would give her "Nido[32]" … they tell you there is no money and this is what we can buy… because you know that the can of "nursie[33]" the small one or any other can of milk will last five days.." (FG6)

In terms of perceived needs, participants referred to basic needs essential to mothers. They highlighted that often mothers ask for diapers, milk, and financial assistance.

HCP: "When they come… immediately they ask for example is there anything distributed? … when we used to do sessions … they wouldn't like for example … "you

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[31] Brand of powdered whole cow's milk
[32] ibid
[33] Infant formula

distribute milk"? or diapers… I mean imagine before entering the session about breastfeeding they are asking about milk…" (FG3).

In summary, barriers to adequate IYCF related to PHCCs included gaps in human and financial resources as well as gaps in human capacity. Mothers face challenges that also contribute to jeopardising recommended IYCF practices.

7.1.3 Participants' recommendations for supporting IYCF – supporting mothers and children.

In order to contribute to improve IYCF, participants recommended an array of activities targeting mothers and children including provision of one-on-one support, access to awareness and education, nutrition support (food and supplements), mental health support, and maternity protection.

One of the main activities recommended by participants to support IYCF and particularly breastfeeding was one-on-one counselling. Participants highlighted the importance of providing counselling and follow up on IYCF for mothers especially by doctors and paediatricians as they are considered the reference and focal point for health messaging by mothers. In addition to doctors, specialists in breastfeeding were referred to as key in providing one-on-one support as they are skilled in providing solutions for problems and breastfeeding difficulties faced by mothers. Continuous follow up and technical support for mothers were highlighted as important to ensure adherence to recommended IYCF practices. See Figure 7-1.

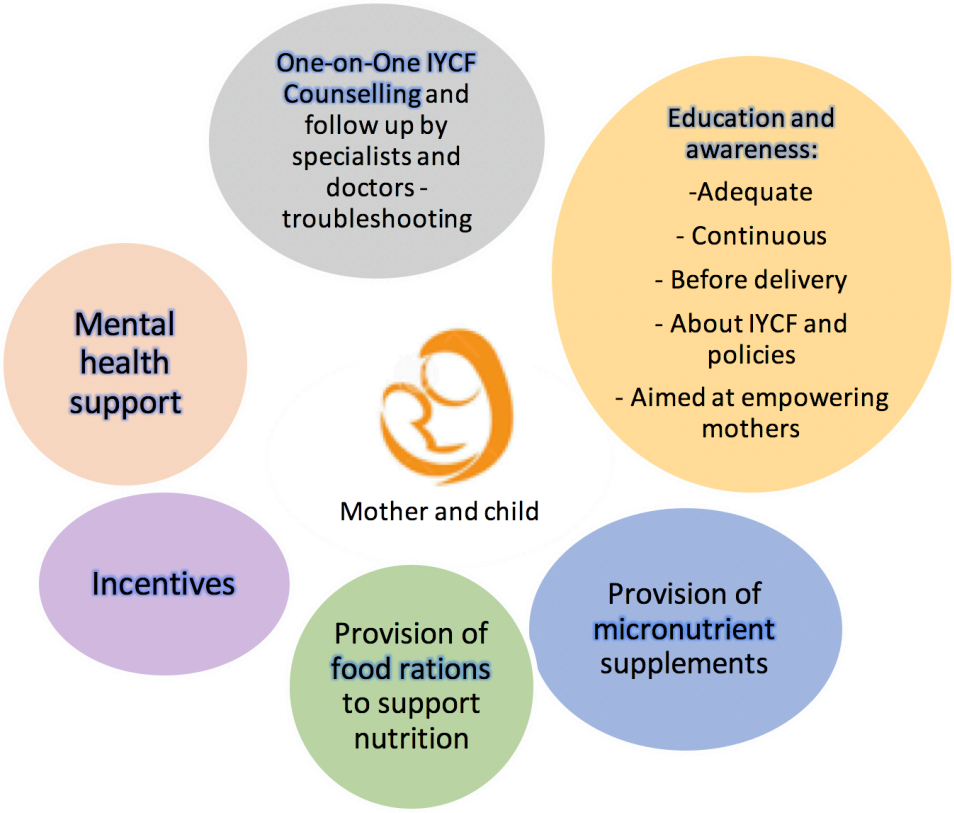

Figure 7-1 Reported recommendations by HCPs for supporting IYCF – supporting mothers and children

> *Nurse: "Me personally, if I want to speak about my personal experience… I feel that I need someone to help me…. I mean, I have had a lot of difficulties with my first baby…. as a mother… I had many problems and my son did not breastfeed for one month… I mean it wasn't until I spoke with someone from [name of supporting organisation], they have people who train… on breastfeeding and they help.... they send them to homes you know?" (FG6)*

In addition to counselling on IYCF, providing psychosocial and mental health support was reported as key given the difficult circumstances in which refugee mothers are living. Staff

spoke about “being there” for mothers and providing them with a safe haven in order to overcome mental stress and difficulties in order to breastfeed successfully. Dispatching a social worker to provide mothers with support was mentioned.

> *HCP: “We should provide comfort for the mother… see the psychological specialist so she can speak with her” (FG9)*

Also, community outreach and identification of mothers through community based interventions was seen as important in order to be able to reach mothers. However, it was noted that this modality of operation was not readily available or practised within primary health centres except when supported by an external organisation.

Education and awareness of mothers were cited as a key intervention to support IYCF. Participants highlighted the importance of providing education before delivery, throughout the pregnancy period and after. Preparation and continuous messaging were highlighted as important in order to help prepare mothers for post-delivery. Key messages that were suggested as important to include in the sessions were the importance and value of breastfeeding and adequate feeding including the cost of not breastfeeding, addressing misconceptions such as breastfeeding and saggy breasts, and optimal nutrition for a lactating mother. Some participants considered the education and awareness as an opportunity to empower mothers so they have the will and dedication to continue breastfeeding.

> *HCP: “The most important thing is awareness, …. always, awareness sessions… for mothers… for example we invite them every few months… an awareness session… things like that” (FG8)*

Participants also highlighted the importance of raising awareness on the existing policies related to the marketing of infant formula. Some thought that if mothers know of the dangers of receiving infant formula for free, they will not accept them as a gift and therefore, it is a way to address the marketing of infant formula. In addition to raising awareness and preparing the mother to breastfeeding, participants saw that providing education and awareness is also a form of emergency preparedness.

> *Nurse: "When you give artificial milk she [the mother] thinks that this is something better for her son… they [the milk companies] challenge them [the mothers] … she is benefiting her son… that he is not getting enough on her breast … that she is benefiting him… we need to clarify that no, it should be that the mother's milk is enough" (FG2)*

Participants highlighted education and awareness need to be tailored to mothers who are illiterate and that developing written material may not be the best way to relay the information.

> *Paediatric doctor: "I feel that speaking with the woman, with the mother, is more beneficial than writing posters because they don't read… sometimes they don't read… or they would be illiterate… because you are working in health centres you will not get the educated people" (FG2)*

Some spoke about conducting mass media campaigns to raise awareness of not only mothers but the community as a whole.

> *HCP: "The Ministry [MoPH] should continue to have a kind of awareness on the billboards on the streets… because really it attracts people to read… always the focus is on breastfeeding … like this, the people will continue seeing and seeing…" (FG4)*

Also, the importance of addressing husbands and men was highlighted as of added value given the role of men in a mother's decision to start and continue breastfeeding and providing adequate feeding.

> *HCP: "Also, I want to add something that is very very important that [name of participant] spoke about… there needs to be education…. for woman and the man… if she [the wife] thinks about giving milk [formula] he [the husband] would tell her never… there is no milk… you need to keep breastfeeding…. he is the one who gives support to the woman… he gives her comfort… if she is a bit reluctant… he would tell her no… it's ok… we will continue and it will be ok…" (FG3)*

Provision of food and nutrition to mothers was repeatedly suggested as key in supporting IYCF especially in emergencies. Participants spoke about the importance of ensuring a mother's nutritional needs are met in order to successfully feed her baby. Instead of giving milk to infants and children, it was noted that it would be best that this milk or other food be provided for the mother. Provision of ready-made hot meals was suggested to ensure that mothers are eating properly. That is, instead of providing food vouchers[34] as the latter was seen as inefficient since mothers are perceived as not using the vouchers in the best way. The suggestion of providing food (and water) to mothers was almost unanimous amongst participants and was seen as highly essential to ensuring adherence to recommended IYCF practices including successful breastfeeding.

[34] Food vouchers are the coupons that refugees receive as electronic cards that they can use in selected food shops.

Nurse: "We are telling her to breastfeed, breastfeed but in this case the most important thing is to provide nutrition for the mother so that her breasts produce and she can breastfeed comfortably" (FG5)

In addition to food, micronutrient supplements were also recommended as important to be provided for mothers to ensure good nutritional status and contribute to successful infant feeding. Participants spoke about "better milk" as a result of such supplementation. These were also seen as incentives for mothers to attend awareness sessions or receive other services.

HCP: "Even if I want to do awareness… if there is nothing in return… we need to distribute something… or they won't come" (FG8)

In fact, provision of incentives for mothers in the form of cash or in-kind contributions was suggested as a possible intervention that would contribute to improved feeding practices. The rationale is that mothers need a motivator especially during emergencies and such incentives would contribute to improved economic status of their families. Mothers will be less "stressed" and would have an easier breastfeeding or feeding journey.

7.1.4 Participants' recommendations for supporting IYCF in emergencies – supporting systems and communities – emergency preparedness.

Participants' suggestions for emergency preparedness included supporting systems like policy and strategy development and implementation, capacity development, resource mobilisation, government support, and contingency stock of supplies.

Participants highlighted the need to implement and monitor existing laws and policies. They mentioned that first and foremost there is a need to have a law and to enforce it.

> *HCP: "There should be laws and there should be legal follow up… be it for doctors or hospitals… even if we had 100 laws and there is no one to follow up and penalise those who are violating it from doctors to hospitals or what have you… health centres… it will not work." (FG4)*

In that context, and given the challenges seen in monitoring of existing policies, participants suggested the engagement of different stakeholders who would play a role in this monitoring.

The MoPH was seen as having the primary role in ensuring enforcement of the policy by providing for example permissions for specific distribution of items or signing agreements with organisations that they will commit to an IYCF policy.

> *Nurse: "Also the organisations when they want to distribute something… they should take permission from the Ministry [MoPH] and within this permission it should indicate what they are distributing" (FG7)*

The role of PHCCs and their staff was highlighted as key in reporting on violations. Centres can play a role in identifying and reporting on violations but also in terms of enforcing existing policies. The role of municipalities in monitoring violations but also in disseminating information was mentioned. The municipality was seen as a gatekeeper for the area with a role in enforcing policies.

> *PHCC director: "Any institution that is coming [into that area] … should stop by the municipality before entering … the municipality should put a protocol [to commit to]" (FG7)*

Participants mentioned on several occasions the role that casa[35] doctors can play. They can contribute to enforcing and implementing the Law and ensuring that there are no donations of infant formula.

> *PHCC director: "The casa doctor… sure, he is the one who has the authority to say no to this or that…. in each area…. so if you convince the casa doctors that this [the distribution of milk] is wrong… that is it… if an organization comes and is distributing…so here the casa doctor can [stop the distribution] …" (FG8).*

Participants highlighted the importance of engaging doctors in primary health centres and hospitals and the need to have legal actions on hospitals and clinics to ensure that doctors are not marketing infant formula.

> *PHCC director: "There needs to be a law that obliges the doctors… even if they are not working within the primary health care … this is a law… it needs to reach them personally [they need to be penalised]… for them…because when you are punished, be sure that you will not do anything wrong" (FG7)*
>
> *HCP: "I mean, if you go into a health centre or a hospital that has milk… it should pay a penalty … the second time it [the centre or hospital] will not repeat it…" (FG4)*

Despite the different suggestions for ensuring monitoring of existing policies, still some participants highlighted the challenges that it would be difficult for private companies or organisations to be monitored because they "don't have an entity above them" (Nurse, FG7) meaning that they are not accountable to a specific entity whether ministry, municipality, etc.

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[35] A "Casa" is similar to a district in Lebanon. Lebanon has 27 Casas and 7 Governorates. Each governorate is divided into different Casas. Casa Doctors are doctors representing MoPH in each of the Casa or district.

Participants also suggested having preparedness plans at both the centre and national level. It was perceived that organisations currently providing support would play a role in developing a centre-based preparedness plan that would include a phase-out plan for the organisation. Plans were also seen as essential at the municipality level and with the assistance of the supporting organisation. It was mentioned that the municipality plays an important role in supporting the centre.

> *HCP: "Actually, there should be a unified program… something called emergency programme or programme for emergencies… something that is specific for mothers and children…. the Ministry should work on it and they should disseminate it on all health centre…." (FG4)*
>
> *PHCC director: "There should be a strategy plan for the centre. It is not there…" (FG5)*

Presence of a capable and equipped centre team with capacity to respond is one recommendation that was noted in almost all meetings. Participants suggested that in order to provide adequate support for IYCF, there needs to be trained specialists as well as skilled, qualified, and committed staff including paediatricians. Participants spoke about the need to have paediatricians "on board" as well as a fully equipped team.

> *HCP: "There needs to be a doctor and a nurse... they are the ones that affect the patient most… they need to be inside the centre … not only counselling... and they need to be qualified" (FG7)*
>
> *HCP Nurse: "You need the paediatrician …to be convinced... because if a regular person is coming here ... they will not be convinced from the nurse... if the doctor told them take milk… we want the doctor for him to be convinced... to encourage breastfeeding... …." (FG5)*

In addition, participants spoke about having financial support from external sources including organisations that support centres. Staff highlighted the role of organisations in supporting any emergency response and examples were given such as providing support in hospitals and clinics.

In order to address the gap in the human resources, it was recommended to increase the number of staff hired. A few examples were given about the need to equip centres with contingency stocks including medicines, baby food and milk.

In summary, opportunities for supporting IYCF during emergencies included those that contribute to equipping PHCCs with necessary tools and capacity to provide the necessary support. Suggestions also include the array of activities needed to support mothers in addition to the set up and implementation of essential policies and plans for emergency preparedness at the PHCC level.

Section 7.2 Results from Focus Groups with Mothers

Eight focus groups were conducted with mothers in four areas; North, South, Bekaa, and Beirut/Mount Lebanon. As described in Chapter 3 ('Methods'), mothers who received services from each of the targeted health care centres were invited to participate in the focus group discussion. From each centre, around 15 mothers were invited. In total, 82 mothers participated (average age 32 years; range 16 to 59 years). Despite the age range, groups were relatively homogenous and mostly resided in the catchment area covered by the PHCC where the focus group was conducted. The number of mothers participating in each focus group ranged from six to 15. All mothers were Syrian refugees who have been in Lebanon for at least the past six months except for one who was Lebanese (married to a Syrian). When quoted, the Lebanese mother is clearly indicated.

During focus groups, mothers were asked about their experiences of breastfeeding and infant feeding as well as the services they received related to IYCF. Mothers were also asked about their perceived needs in support infant and young child nutrition (Appendix 6). Focus groups were conducted in colloquial Arabic/Lebanese which is a similar dialect to the Arabic/Syrian and all conversations were in Arabic. On average each focus group discussion took around 40 minutes. Discussions were recorded and transcribed in Arabic and then translated into English by the researcher as described in Chapter 3, Section 3.3.6 'translation of transcripts'. Transcripts were analysed using a thematic approach and a verification process was adopted also described in Chapter 3. Section 3.4 'Analysis'.

As mentioned in Chapter 3, Section 3.3 'Methods', an awareness session was planned to be administered to mothers after the focus groups. During the focus groups, the research identified a number of issues that needed follow up including the recurrence of misconceptions related to feeding. Therefore, following most of the focus groups, the session included tackling some of these misconceptions or emerging issues.

The following are the main themes and findings that emerged from the focus groups with mothers.

7.2.1 Breastfeeding practices - commitment to breastfeeding with social, cultural and physical factors affecting the success of breastfeeding.

Breastfeeding and infant feeding practices varied with some participants successfully initiating and continuing breastfeeding and those who did not breastfeed at all. Through the focus groups and when inquiring about breastfeeding practices (current and previous), the majority of participants indicated that they breastfed, however the difference was mainly related to the number of months breastfeeding and to the timing of introducing solid foods.

In general, participants perceived breastfeeding as important and beneficial for children's health and showed commitment to breastfeeding. It was sometimes seen as an obligation and even a sacrifice but at the same time a custom, especially in Syria.

> "*Mother 1: I cannot NOT breastfeed her because she is still small and us in Syria we breastfeed till two years"*

Mother 2: "My blood[36] is decreasing, my calcium decreases because of breastfeeding but at the expense of my health, I feed my daughter" (FGM1[37])

There were several indications that customs relating to breastfeeding differed between Lebanon and Syria. In general, participants' experiences of breastfeeding seem to have been better in Syria than in Lebanon. Examples of increased consumption of infant formula in Lebanon as compared to Syria were given.

Mother: "In Syria …you feel that the consumption of milk in a can[38] is less than here. Now for example we are here and I know more than one [mother], that's it, milk in a can. Her children are not getting enough. Why is that? In Syria, we used to get enough and here we are not getting enough" (FGM1)

Despite the commitment, participants shared reasons and challenges that led them to discontinue breastfeeding. The most common reason that was cited was having to stop feeding because of "*not having enough milk"*.

Mother: "By God[39] I gave him [my breast] and by God there is no more milk" (FGM2)

Participants based the perception of not having enough milk on symptoms such as constant crying and the child not sleeping well and indicated having to stop breastfeeding or supplementing to solve these problems. Having twins was also reason to supplement with formula since a mother will not have enough for both children.

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[36] "My blood" = referring to Iron in the blood.

[37] FGM stands for Focus Group with Mothers and the number refers to the order of the conducted focus group. For example, FGM1 is the first one conducted out of the total eight focus groups.

[38] ''Can" refers to the can of powdered infant formula

[39] "By God" = This expression is common in sentences and means "truly" or "really".

Mother 1: "By God, she has twins"

Mother 2: "And it wasn't enough for them so I had to bring them milk"

Interviewer: "How do you know that they are not getting enough?"

Mother 2: "They don't sleep, they cry and when they eat a full meal you feel they sleep about two hours" (FGM8)

The perception that the child not gaining weight was another perceived reason for stopping breastfeeding or supplementing with formula or even starting solid foods. Maternal nutrition was also considered a factor for not having enough or "good" milk. Some participants shared how they had fully breastfed their children in Syria but did not do so in Lebanon due to lack of perceived good maternal nutrition.

Interviewer: "How long did you breastfeed your son in Syria?"

Mother: "Around one year, … all of them [my children] they breastfeed…"

Interviewer: "And this child [who was born in Lebanon]"

Mother: "Breastfeeding with milk [infant formula]"

Interviewer: "Why do you think this happened?"

Mother: "there is mother's nutrition… the eggs, the milk… it's all shortage…" (FGM2)

There were a number of other cultural, social and physical factors that were cited as contributing to stopping breastfeeding. Being pregnant was perceived by many participants as a reason to stop breastfeeding. Participants reported that as they got pregnant, they would stop breastfeeding their older child. Statements such as "I am not breastfeeding because I am pregnant" and "I weaned, I am pregnant" were often mentioned during the focus groups. In addition, participants referred to doctors advising stopping breastfeeding due to a new pregnancy.

Mother: "The boy I breastfed him nine months [only] because I was pregnant …I went to the doctor she told me you have to stop breastfeeding immediately ……I stopped" (FGM1)

Tiredness and stress (mental and psychosocial health) were given as reasons for unsuccessful breastfeeding or having to stop breastfeeding. A few also related to a change in environment where mothers indicated "losing the milk" upon arrival to Lebanon.

Mother: "Here there are psychological situations. The woman [40] would be tired psychologically. She cannot [breastfeed] … this is what happens most of the time" (FGM5)

The effect of sadness on mother's milk was mentioned. Mothers narrated how a sad and depressed mother should not feed her child, otherwise "*her milk will make him sick…He drinks and he becomes sick …he vomits when the mom is sad and she breastfeeds when she is tired he vomits the milk immediately" (FGM6).*

Fasting during Ramadan when breastfeeding was also cited as affecting milk production although mothers did not say that they stopped breastfeeding because of fasting.

Mother: "Fasting 16 hours and tired all day, you cannot. So that you don't get dizzy. It's difficult" (FGM3)

Other cultural factors included stopping breastfeeding due to the "evil eye". A mother recited how her milk stopped due to her neighbour who visited her while she was feeding her child. The mother reported that she was feeding her child normally and one day a woman came to her house and she believes that she was the reason behind her inability to continue breastfeeding. Within the focus group, other participants indicated familiarity with this concept.

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[40] It is customary to speak in the third person within a conversation. In this example, the participant means "one would be tired".

Mother: "I breastfed until four months, after four months …. He wouldn't take my breast. Why I don't know. One woman came over and she 'jinxed me' so my breast went dry… yes, I didn't have anymore milk and this is how I resorted to the milk [formula]" (FGM8)

7.2.2 Complementary feeding practices – early or late introduction of solid foods with varied quality of food.

Participants reported the introduction of solid foods at different ages. Some indicated introducing solid food as early as two months, others at four months while a number confirmed introducing solids after six months. Some participants mentioned advice from doctors about early introduction of solid foods and other liquids.

Mother: "When she was two months I took her to the doctor and I told him that she is not getting enough and all day she cries. He told me start with yoghurt... I started diluting it with water... this was in Syria… he told me put some sugar and water and dilute with water it becomes 'Iran[41]' and you start with it. By God I started for her and every day she was becoming healthier" (FGM1)

Knowledge about optimal age of introduction of solid foods also differed. Some indicated four months, others six months and others nine months.

Mother: "At four months I started bringing Cerelac[42] with my breast. I continued with Bledine[43] to feed her until one year and nine months from my breast. But she didn't eat. Only Cerelac and Bledine and things like that. The [real] food she doesn't eat" (FGM1)

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[41] Diluted form of yogurt that usually contains salt.
[42] Brand of baby cereal.
[43] Brand of baby food.

The quality of the food given to children also varied. Some participants were focusing on limiting complementary food to cereals and milk while a few spoke about providing fruits, vegetables, and regular family food. There was an impression that complementary feeding consists of puréed food that is largely made of yogurt, potato, and eggs.

Mother: "…I feed him fried eggs, yogurt, rice. He eats rice and yogurt" (FGM3)

Challenges related to complementary feeding and solid food were also commonly mentioned, the majority of which included those related to picky eating and difficulty in feeding the child. Responsive feeding was also mentioned where some participants indicated the challenge of feeding an infant amidst the difficult conditions they are living in.

Mother: "He likes to eat with his hand. Sometimes he doesn't accept to eat unless it is with his hands. He stays for 2-3 days without food."

Interviewer: "What is the problem that he wants to eat with his hands?"

Mother: "He will get himself dirty …the environment here... she [the neighbour] will start 'bullying' you [me]. She will tell you 'ooooh MY son does not eat with his hand." (FGM8)

In summary, participants reported challenges related to feeding their infants including those related to difficulties with breastfeeding such as not having enough milk and complementary feeding.

7.2.3 Livelihood and assistance challenges.

There were difficulties and perceived needs mentioned by participants that included those related to humanitarian assistance. These issues are not directly related to infant feeding but rather to the general economic and social situation, which might indirectly

link to food security. Participants highlighted the shortages in humanitarian assistance in general and described the assistance provided by the UN as insufficient and "unfair". Mothers indicated the UN is not targeting families properly, highlighting that only families with a large number of household members would receive assistance and that other families were excluded. Some mothers linked this kind of assistance to encouraging families to conceive more children and therefore worsening the situation of food security and socio-economic status.

> *Mother 1: "They [the UN] don't help neither with milk nor with anything …"*
>
> *Mother 2: "They tell me what? You only have a daughter…then me my husband cannot take care of himself…they tell me we are giving large families. My neighbours have four children and now got triplets they now have seven children …they [the family] told me at their [the UN's] expense we are delivering, at their expense we are feeding them [our children] and at their expense we are giving them to drink …God bless them, I am not saying anything, but the UN should limit this so that they can help the other families." (FGM2)*

7.2.4 Services related to infant and young child feeding.

Participants were asked about the services received related to nutrition for their children under two years of age; few services were cited. The main service that was reported was the opportunity to attend an awareness session on breastfeeding in the PHCC. However, not all participants had the opportunity to attend such a session but many mentioned benefiting from the information which highlighted the importance of breastfeeding and the techniques of breastfeeding.

> *Mother 1: "We attended a lecture … about the mother who breastfeeds and holds her breast*

like this for the baby like the scissors"

Mother 2: "The milk has two stages, I don't know what was the first but the second means half fat and full fat"

Mother 3: "Yes, I learned [from the session] and when you attend the session, you feel that there is information that you have missed before" (FGM6).

Other services that were mentioned, although not consistently within all groups were micronutrient supplementation.

Mother: "Yes, here in the centre they give me calcium pills and vitamins" (FGM1)

Delivery of obstetrics services was also reported, but very few participants acknowledged receiving breastfeeding counselling (i.e breastfeeding support post-delivery). A considerable number of participants indicated not receiving any assistance related to infant feeding and nutrition. In many cases, the researcher had to probe during the interview to inquire about certain services which participants did not relate as being linked to infant feeding and nutrition; these included attending an awareness session, receiving micronutrient supplementation, or counselling on breastfeeding. In a few instances, mothers gave examples of how the counselling benefited them and was key to encouraging and supporting them to breastfeed. When mentioned, the counselling was usually provided by a specialist who was employed by a supporting NGO.

Mother: "I benefited 100%, I stayed 10 days and said I will not bring her milk, I need to breastfeed her. When I spoke with the specialist I was encouraged more that I should breastfeed her … When she spoke to me she encouraged me. She gave me an incentive. I felt that I have to. That it is for her [the baby's] own body especially because of the diseases and such" (FGM6)

There was an impression that assistance on IYCF would consist of providing in-kind assistance such as food and infant formula. In fact, a few participants who indicated not receiving any assistance highlighted that there was no infant formula distributed.

At the same time, and in addition to the perceived lack of assistance related to infant feeding, participants gave examples of the kind of advice they received from doctors. Although not consistent, some participants reported doctor's advice which was not in line with recommendations. For example, it was reported that doctors would advise mothers to wean if pregnant and to provide infant formula when "there isn't enough milk".

> *Mother 1: "At the beginning my breast [milk] was enough for her but since 1 week, she started crying crying. I took her to the doctor, he said she is not getting enough from the milk …. I started giving her milk [infant formula]"*
>
> *Mother 2: "I weaned her…I got pregnant …it will hurt her … the doctor said to wean ….and I give her milk Nido*[44]*"*
>
> *Mother 3: "They took him to the doctor … he said the child is not getting enough milk" (FGM3)*

7.2.5 Participants' recommendations to support infant and young child feeding - providing nutrition and support.

Participants shared perceived needs and suggestions related to IYCF. Such needs included general assistance, milk for infants, diapers, food and nutrition for mothers as well as for the family, medicine and health care. Participants linked optimal breastfeeding to their

[44] Whole cow powdered milk.

own food intake and nutritional status. They emphasised that provided the mother has enough food and good nutrition, then her milk would be enough and appropriate to feed her baby. Participants recommended that in order to support mothers to breastfeed, there should be provision of meals to mothers in the form of hot meals or even ready-to eat meals. Food and nutrition was also highlighted for the children and for the family where it was noted that providing food for the family will contribute to a mother's nutrition as well.

Mother 1: "Nutrition for the mom [is needed to support breastfeeding] dear"

Mother 2: "Good nutrition"

Mother 3: "The mother needs nutrition …because whatever she eats, she gets milk …now milk, it will come, but if mother eats, milk will come and be good …. the mother [should receive assistance not the child]" (FGM3)

Milk and diapers were also cited as a necessity including infant formula. Participants recommended that there should be provisions of milk/infant formula for infants who are not breastfeeding.

Mother: "Milk, give us artificial milk. Nothing is working" (FGM5)

Participants found that providing financial assistance and improved living conditions would contribute positively to infant feeding. They linked improved living conditions with better mental and psychological status and therefore improved ability to provide for their children including breastfeeding.

Mother: "Mental support is very important …it is when you sit down and speak to others about what is working and what is not working … we understand each other … a tip from here a tip from there … it is not little; it is useful" (FGM6)

Providing support in the form of counselling was not always recognised as an actual intervention by participants although it was acknowledged that such services are of added value. During focus groups, mothers with success stories shared how a lactation consultant helped them overcome barriers and challenges in breastfeeding. One spoke about a re-lactation experience where because of the support she received from the specialist she was able to re-initiate breastfeeding after having stopped. This recounting of the story made other mothers aware of such a service and realised the importance of endorsing this intervention. In most cases, when a specialist was mentioned, she would be from a supporting INGO.

> *Mother: "There is a specialist, she comes to your house, she asks about the baby and she teaches me what to do. Really there were things I did not know in breastfeeding like when to breastfeed. I used to breastfeed haphazardly …at one point I thought that is it, I want to buy milk. I couldn't. At about three months or a bit more. I didn't want. So Dr. [name of doctor] spoke to the specialist and she came. So there was support. Thank God better than before. My milk was about to dry out but thank God now it increased. …the mental support is much stronger than medication" (FGM6)*

Medicine and health care were also indicated as a need for mothers and families that would affect infant feeding through improved health conditions.

In summary, findings show that the main services that mothers receive are related to awareness with some centres providing counselling on infant feeding. Perceived needs revolve around in-kind assistance for nutrition, health, and humanitarian assistance in an

attempt to improve nutrition and living conditions which in turn improve feeding practices.

Section 7.3 Discussion of Findings at the Service Provision Level

This part of the research examined the Case (IYCF-E policies and programmatic activities) at the service provision level through the administration of focus groups with HCPs and mothers. This discussion reflects on results from focus groups (with HCPs and mothers) and the literature including the document review (Figure 3-4).

7.3.1 Policies and programmatic activities.

In Lebanon, the majority of primary health services are provided to Syrian refugees through the primary health care system (Lyles & Doocy, 2015). Given the protracted crisis in the country, direct implementation by NGOs is not promoted by the MoPH, which instead encourages NGOs to support the health system in providing appropriate support[45] (GoL & UN, 2016). PHCCs are therefore considered the frontline support for mothers and infants and this makes it even more important to ensure that IYCF policies are translated to this level.

Findings in this study show that although IYCF policies exist at the national level, these were not found to be documented at the service provision level. This is considered a gap in policy implementation since existing documents did not trickle down to lower levels. No emergency preparedness plans were noted either.

[45] For example, the government does not encourage organisations to directly provide services to families but rather to do so through existing health care systems.

On the other hand, the promotion of specific standards of practice indicate that there are efforts to translate existing policies into practice. As Gilson (2012) notes, the "daily practices" are also considered a "health policy as it is experienced", so the informal unwritten practices can be considered as a way of implementing the policies. Mkontwana, Steenkamp, and Von der Marwitz (2013) examined the implementation of IYCF policies amongst health care workers in South Africa and reported that 56% of participants claimed they had never seen the IYCF policy; although they had good knowledge about the policy content (as evaluated through test scores). Knowledge about some elements of the policy were therefore noted.

Knowledge about policy content was limited to the need to prevent distribution of infant formula and the importance of promoting breastfeeding. A number of policy recommendations were not translated into practice and did not feature in the focus groups. For example, the joint statement on IYCF-E issued in 2012 (Appendix 11), clearly states that mothers and infants should be assessed prior to providing any artificial feeding support, but there was no indication that HCPs were aware of this guidance. There were some indications – although weak - that this guidance was or used to be violated (through reported untargeted distribution of infant formula). It was evident that there are disparities in the understanding and awareness of IYCF policies as well as providing adequate support amongst HCPs. The gap in policy implementation may be due to the lack of operational guidance for the implementation of the existing policy (Prudhon et al., 2016; Webb et al., 2014).

The missing enforcement of policy recommendations was also reported through the described activities. The majority of activities targeting mothers were promotion and awareness on IYCF with ad hoc counselling and a lack of homogeneity in the services provided between centres. Counselling is an integral part of IYCF services (UNICEF, 2012) and ensuring it is provided to mothers will contribute to improving IYCF practices. Another service that was found lacking and that has been cited by the literature is community outreach. A number of programming guides have highlighted the importance of community outreach; UNICEF (2013a) reported that the largest increase in exclusive breastfeeding was seen in Benin where the programme included community activities. Although challenging in terms of cost, human resource requirement, supervision etc., it is worth considering ways for integrating community outreach within primary health centres in Lebanon.

A noticeable finding is that in most cases IYCF services at the service provision level were supported by an external organization (NGO) and geared by individual commitment. This dependence is important given that it contributes to the lack of sustainability of activities. It is evident that IYCF services are not well institutionalised or integrated. This dependence on external organisation in the context of emergencies has been reported previously; Bassil et al. (2016) in an evaluation of an IYCF-E programme in Jordan, noted the lack of a sustainability plan for the phase out of a programme that is fully funded through an INGO. On the other hand, having a strong willed and committed centre

manager who has IYCF as a priority and is willing to enforce policies and guidance was seen as essential for the implementation of IYCF activities. Leadership and political will is a key factor in moving IYCF forward even at the level of small institutions such as a PHCC (UNICEF & WHO, 2015).

7.3.2 Issues and barriers.

Issues and barriers for IYCF support have been identified at the service provision level from both HCPs and mothers. These relate to the quality and capacity of services as well as the challenges that mothers face hindering the advancement of IYCF.

7.3.2a Lack of professional support.

Issues around the provision of professional IYCF support were identified. These include i) lack of capacity and knowledge amongst HCPs (and doctors specifically), ii) the lack of human and financial resource, and iii) the challenge of addressing the marketing of infant formula (Figure 7-2).

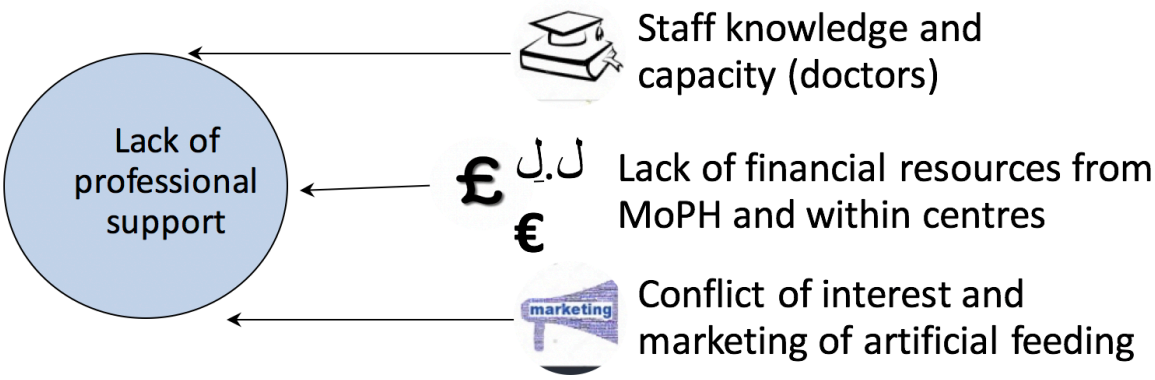

Figure 7-2 Summary of identified barriers to adequate IYCF related to provision of support at the service provision level

Link to staff knowledge and capacity

Gaps in capacity of providers were noted both in terms of knowledge and time. Focus groups in this study did not reveal specific competencies that were missing except that HCP participants referred to lack of capacity, possibly meaning technical capacity such as knowledge about IYCF and the capacity to adequately counsel mothers. During emergencies, there are essential skills and competencies that are needed (Swords, 2007). Meeker et al. (2014) developed a framework for competencies during emergencies specifically for health and nutrition staff. The main behaviours that were highlighted included understanding and adhering to existing IYCF-E guidance and providing support for breastfeeding. The framework also included ensuring appropriate measures are taken to minimise risks of artificial feeding. These behaviours were inconsistent at the service provision level, although there were reports of HCPs attending capacity building trainings

on IYCF. Mkontwana et al. (2013) examined the implementation of IYCF policies amongst health care workers in South Africa and reported that the main challenges include the capacity of HCPs and the lack of monitoring of counselling and training. It would be useful to conduct a Knowledge Attitude and Practices assessment as done by Bassil et al. (2016) to assess staff capacity. It is notable that in the mothers' focus groups very little reference was made to receiving one-to-one guidance related to breastfeeding. The only examples where mothers shared a positive experience concerning assistance in breastfeeding was when it was provided by a specialist hired by a supporting organisation. This finding highlights the lack of institutionalisation and integration of IYCF activities and services within the health system. It also emphasises the importance of investing in assessment of capacity and training of staff.

Regarding advice given to mothers about IYCF by doctors, there were instances when mothers reported advice that was deemed inappropriate e.g. introducing solids at an earlier age than recommended. It is possible that mothers might have misinterpreted this advice although this also raises issues about communication between doctors and others. However, these findings also match with results from the HCPs who often elaborated on the lack of capacity amongst doctors. Gaps in knowledge amongst paediatricians have been reported elsewhere in Lebanon (Nassif, Noueiri, Bacho & Kassak, 2017) and the wider region (Vandenplas et al., 2017). Akik (2014) also reported gaps in knowledge and capacity amongst doctors, including paediatricians and gynaecologists.

Gaps in counselling might also be linked to the shortage in the number of available human resources as well as the absence of time to provide adequate advice. Staff did report being overburdened and not having enough time to allocate to provide counselling or awareness to mothers. Lack of human and financial resources leading to weak monitoring and capacity to enforce policies fits with identified barriers by Pérez-Escamilla et al. (2012).

It is recognised that access to adequate IYCF professional support is often a concern during emergencies given the challenging circumstances. There is therefore an urgent need to equip staff with the skills as a preparedness measure to ensure the best response during emergencies.

Link with lack of financial resources

Gaps in professional support were linked to lack of financial resources. Since the start of the Syrian crisis, financing of services at the primary health care level has been mostly through UN and international agencies. The latest Government of Lebanon and UN response plan included a total budget of US$2.8 billion to provide humanitarian assistance. Included in the plan is assistance to improve access to comprehensive primary health care with a budget of US$83.4 million. The plan acknowledges the need for interventions to promote exclusive breastfeeding and appropriate feeding practices. It also includes targets related to including health awareness at health facilities and capacity building for staff. The plan does not however include clear language about provision of

skilled support through trained individuals (GoL & UN, 2016). In addition, although the budget is set, securing the funding and the prioritisation of activities related to IYCF remains an issue. Financing of similar plans has always been a challenge, and previous response plans were underfunded with funding reported to be at only 30% (Foundation Center, 2017). Amidst the lack of funding, there is a concern about which activities or outcomes are prioritised including those related to IYCF.

Link with marketing

The influence of formula companies on the uptake of recommended feeding practices has been well documented (Piwoz & Huffman, 2015). In the findings from HCPs and mothers, it was clear that the challenge of addressing the marketing of infant formula was there and seems to be affecting HCPs, namely doctors' advice related IYCF. It was not clear whether the reported inappropriate advice arose from a lack of awareness in IYCF or from direct influence of the marketing of infant formula especially that the marketing did not seem to be overt. Kirk et al. (2012) noted a lack of understanding around the international Code by HCPs, specifically where doctors did not value the need to make their clinics more "Baby-Friendly[46]" since they believed that it was a mother's choice to breastfeed not their role. Recently, Akik et al. (2017), through a stakeholder policy analysis on IYCF in Lebanon, reported that the health care system, including doctors, is influenced by BMS companies. They reported instances where companies marketed their products to health

[46] Referring to the different steps required to make the clinic more encouraging to breastfeeding, similar to the Baby-Friendly Hospital Initiative.

professionals through awareness sessions for physicians and even for mothers. In Lebanon, paediatricians are the primary providers of care for children. They are considered the first reference providing both health services and health education to parents and children. They play an important role in supporting IYCF practices and in many cases influence a mother's feeding decisions (Keim, Tchaconas, & Adesman, 2017). Piwoz & Huffman (2015), through a literature review using the theory of planned behaviour, showed that there is clear evidence that BMS, especially when promoted by health workers, has a negative effect on breastfeeding uptake and continuation. It could be that increasing awareness (e.g. stronger dissemination of existing policies) to doctors might result in improvement in feeding practices. However, there may be a need to put in place clear guidance and possibly legal regulatory processes or disciplinary measures to correct such actions.

7.3.2b Issues related to mothers.

During emergencies, there are a number of factors that undermine appropriate feeding, including the widespread misconceptions around breastfeeding. In this study, several issues were raised by mothers and HCPs that needed to be addressed and that affected feeding practices. These issues, recognised by HCPs and observed amongst mothers during the focus groups, are found throughout the world. Alshebly & Sobaih (2016) noted that the adequacy of breast milk production was a major problem encountered amongst Saudi women. Balogun, Dagvadorj, Anigo, Ota, and Sasaki (2015) reviewed factors influencing breastfeeding and reported that maternal perception of insufficient breast

milk was very common. In addition, the study also found socio-cultural factors similar to those identified in this study such as maternal and significant others' beliefs about infant nutrition which also often constitute strong barriers. The role of men was acknowledged as key to supporting breastfeeding. A recent barrier analysis conducted in Lebanon with Syrian refugees showed that one of the main barriers to breastfeeding was the role of husbands (Perera & Reese Masterson, 2016). The analysis found that non-breastfeeding mothers were 6.9 times more likely to say their husbands would disapprove of breastfeeding than breastfeeding mothers.

Acknowledging and addressing misconceptions is important in IYCF support. Mulford (2008) discussed the importance of acknowledging these misconceptions and ensuring that health providers do not "medicalise" infant feeding. Others, such as Balogun et al. (2016) and Debevec and Evanson (2017) also concluded through a review of the literature on breastfeeding barriers and women's experiences that HCPs should be informed about the determinants of breastfeeding and provide practical anticipatory guidance targeted at overcoming these barriers. These issues highlight the need to ensure that mothers are well counselled and provided with adequate education and awareness about the importance and practical aspects of feeding especially during emergencies. The different issues that mothers raised indicate the topics that should be covered in the education sessions beyond knowledge about health benefits such as those related to misconceptions. The issues also indicate that services are not yet attending to the mothers' needs.

7.3.3 Plausible approaches and opportunities.

Both HCPs and mothers agreed on main interventions that would contribute to the support of mothers in feeding their infants during emergencies. Provision of food, mental health support, counselling and support as well as addressing the most immediate needs of mothers are interventions that match international guidance on emergency programming.

Mental health support has been recommended to be integrated within IYCF and other nutrition programmes given its value in contributing to improved maternal care (Bizouerne, 2012; Richardson & Walters, 2014). Psychological factors including stress can influence the transfer of milk (Jonas & Woodside, 2016); at the same time breastfeeding has been shown to decrease the risk of maternal depression (Kendall-Tackett, 2015) and contribute to improved mental health (Lee et al., 2016). It has been reported that 34.5% of Syrian refugee adults in an area in Lebanon have post traumatic stress disorder (Kazour et al., 2017). During emergency and crisis situations, there is an increased need to ensure that mental health is addressed in order to contribute to improved maternal care.

Food assistance is considered one of the main interventions during emergencies, and both mothers and HCPs highlighted the importance of providing food to mothers as a way to support IYCF. In times of food insecurity, adult family members including mothers tend to skip or reduce the size of meals (Bickel, 2000) to give room for children to eat. In this

study, mothers regarded their nutrition as vital for the success of breastfeeding. It is true that differences in nutrient content of breast milk can occur as a result of poor maternal diet and reserves, specifically for water soluble vitamins (Allen, 1994; Kramer & Kakuma 2004; Picciano, 2001). However, given the value that breastfeeding has in terms of preventing mortality and morbidity through immunological benefits, the recommendations highlight the importance of supporting breastfeeding and supporting maternal diet.

Awareness, support and counselling constitute major contributing factors to the improvement of feeding practices. A main opportunity that stemmed from HCPs is the importance of providing awareness and support to mothers. Although awareness activities are important, these need to be structured in a way where multiple channels of communications can be utilised. UNICEF (2013a) reported while examining IYCF programmes in six countries that having multiple outlets to deliver IYCF messages was found to have a bigger impact than only providing awareness raising approaches through a single outlet. In addition, providers spoke about incentives for mothers to participate in awareness activities. Considerations about incentives is worth investigating. Moran et al. (2015) reviewed the evidence on the effect of providing incentives for breastfeeding compared to no incentive. The results were mixed, and it is unclear whether providing incentives to mothers is a good investment. The Nourishing Start for Health trial also tested the impact of providing shopping vouchers for mothers on breastfeeding rates (Relton et al., 2016). Other incentives for breastfeeding might also include empowering

and targeting men and other influencers. For example, including men and grandmothers in the education sessions might be an incentive for mothers to breastfeed given the role they play in affecting breastfeeding exclusivity and continuity (Negin, Coffman, Vizintin, & Raynes-Greenow, 2016; Perera & Reese Masterson, 2016). In fact, the socioecological model for behaviour change highlights the importance of influencers, "interpersonal" interactions that shape behaviour (Sharma, 2016). At the same time, given the influence that mothers have on each other in terms of practice, it is worth investigating the value of peer support groups. Mother care groups have been shown to have an impact on breastfeeding in both normal and emergency situations (Shakya et al., 2015) and it might be useful to make provisions for the establishment of cost neutral mother support groups in the absence of human resources.

HCPs dwelled on the importance of supporting the health care centres both with in-kind support as well as human capacity. The presence of skilled support for IYCF is important given the role that specialists play in providing advice and guidance to mothers. Patel & Patel (2016) recently reviewed the evidence related to the effectiveness of lactation consultant and counsellors on breastfeeding outcomes, concluding that such interventions contribute to improved breastfeeding practices. Therefore, a key measure at the service provision level, is to ensure skilled human resources are available to provide adequate support for mothers.

There were a number of successes that were mentioned during the focus groups with HCPs and mothers that one can build on to advance IYCF support. For example, the positive experience that one mother had with re-lactation and the successful counselling that some HCPs referred to can be the basis for efforts to support IYCF. Similarly, the success of one centre supported by an external organisation is also another example of how centres can be equipped. These success stories can serve as a starting point to enhance the capacity of centres to provide the needed IYCF support. Johnson, Kirk, Rosenblum, and Muzik (2015) reviewed interventions and strategies that impact breastfeeding in low-income African American mothers and concluded that an effective intervention strategy requires a comprehensive multilevel approach that is based on the social ecological model. They highlighted the need for an integrative approach that addresses the different factors affecting a mother's decision to start and continue breastfeeding. During emergencies, this consideration becomes even more important given the lack of social support structures and difficult circumstances.

7.3.4 Conclusion.

At the service provision level, it is evident that some standards of practice and activities related to IYCF do exist, however these are not fully aligned with international and national guidance. IYCF services within primary health centres are dependent on external support and thrive through individual commitment. In order to ensure adequate and equitable IYCF services, there is a need to ensure policies are disseminated, promoted

and implemented through extensive capacity building and institutionalisation of comprehensive services.

Chapter 8 IYCF-E POLICIES AND PROGRAMMATIC ACTIVITIES - THE CASE: CONVERGENCE OF FINDINGS AND DISCUSSION

Infant and young child feeding (IYCF) plays an important role in shaping a child's health with implications later in adulthood. During emergencies, ensuring adherence to recommended IYCF practices becomes even more important. Globally, IYCF guidance and policies are in place to ensure appropriate practices are supported in emergencies. However, these are seldom implemented. Lebanon has a history of national emergencies and poor feeding practices are prevalent. To respond adequately in emergencies, and since Lebanon is currently host to a large number of refugees, there is a need to explore existing IYCF-E policies and programmes.

This research examined the Case of existing IYCF-E policies and programmatic activities in Lebanon during the period between 2012 and 2015 to provide a basis for emergency preparedness for this and future crises.

The objectives of this research were:

1. To review and critically evaluate the content of current policies and practice based guidance related to IYCF in emergency situations in Lebanon with respect to concordance with international recommendations.

2. To identify and critically evaluate current implementation of policies and programmatic activities related to IYCF in emergency situations operational in Lebanon with respect to concordance with international recommendations.
3. To identify barriers to implementation of national and institutional policies and programs related to IYCF in emergency situations in Lebanon that comply with international standards.
4. To explore plausible approaches and opportunities to guide the development of effective policies and programmatic activities that optimise IYCF in emergency situations in Lebanon.

In order to address these objectives, the Case of IYCF-E in Lebanon was examined by exploring IYCF-E policies and activities that are *documented* (through the document review), those that are *reported and implemented* by active agencies (through the NGO questionnaire), those *reported and implemented* by HCPs (through the focus groups with HCPs), and those *received* as services by the end users (through the focus groups with mothers). A critical realist approach was adopted whereby the different levels of explorations allowed the provision of knowledge about the three levels of realities including the empirical, the actual, and the real (Figure 3-2).

This chapter presents a synthesis of findings from different stages of data collection and units of analyses. It is a convergence of multiple sources of evidence as described by Yin (2014, p. 121). The chapter does not repeat results. It rather offers an overview of the

Case and addresses the research objectives. For each objective, a suggested schematic explanation is provided that abridges the findings and offers a summary of the knowledge acquired. For objectives three and four, causation was suggested which helped explain the phenomena in question and suggest practical plausible approaches to address the problem as suggested by Fletcher (2016) in critical realism. This chapter also includes a section on strengths, limitations, implications and a final conclusion.

Section 8.1 Content of IYCF-E Policies and Guidance and Alignment with International Guidelines

The first research objective concerned the extent to which IYCF-E policies and guidance in Lebanon are in line with international guidelines. As described in Chapter 4, Section 4.1 'Global IYCF, IYCF-E Policies and Guidance', globally, there are policies pertaining to governments and countries in general (i.e. applicable to the central level and service provision level) such as the Code (WHO, 1981); the GSIYCF (WHO & UNICEF, 2003); and the WHO guiding principles on IYCF-E (WHO, 2004). There are those specific to organisations working in humanitarian contexts; namely the OG-IYCF-E (IFE Core Group, 2007) and the Sphere Project (Greaney et al., 2011). These also apply to service providers. Having well-established IYCF-E policies is key to ensuring preparedness for emergencies and sustaining IYCF-E (IFE Core Group; Borrel et al., 2001).

In assessing alignment of existing policies in Lebanon with international policies, first an *account of existing national policies* was completed. The main relevant national policy

documents at the national (central) level are Law 47/2008 (RoL, 2008) and the joint statement on IYCF-E issued in 2012 as a result of the Syrian crisis (MoPH et al., 2012). Despite the few other policy documents that were referred to such as the BFHI and a law related to consumer protection, Law 47/2008 and the joint statement were the only ones that were directly relevant to IYCF and IYCF-E and were available for review. At the organisational level (INGOs and LNGOs), very few documented policies existed despite endorsement of international and local policies by some NGOs. At the service provision level, policies were less apparent and documentation of written policies was non-existent; although in some instances the existence of policies was acknowledged. The combined results from this research, showed the existence of national policy documents at the central level, but very few organisational policies, and a lack of written policies at the service provision level.

In terms of the *content* of existing national policies, it was found that they are aligned with existing international guidance, however gaps exist due to the lack of any preparedness plans on IYCF-E. As detailed in Chapter 4, Section 4.2 'IYCF and IYCF-E Policies, Guidance, and Programmes in Lebanon', Law 47/2008 is a complete translation of the Code including clauses related to the banning of the marketing and free distribution of BMS. Similarly, the joint statement is based on a model statement for emergencies that is used in humanitarian situations. Having a law that translates the Code is of added value given the legal boundaries for implementation of the Code. In fact, Lebanon is one of the few countries following the WHO recommendations to implement the Code in its

entirety (IBFAN, 2016). Even the United States has not done so (Soldavini & Tallie, 2017). It is also considered an emergency preparedness measure (WHO & UNICEF, 2003). The presence of the issued joint statement on IYCF-E is of added value since it translates the OG-IYCF-E. The joint statement was mentioned in the WBTI country report as a comprehensive policy for emergencies (IBFAN, 2015) and it was reported that Lebanon was one of the few countries having a written IYCF-E policy (Gupta et al., 2012). The presence of such policy indicates the potential for good preparedness and support for IYCF-E. However, this policy is not integrated within MoPH's health strategies or emergency plans[47] and remains a stand-alone document. That the work on issuing the statement was spearheaded by non-governmental agencies indicates a gap in the sustainability of this policy. There is no institutional memory to contain the statement and in the event of another crisis, there is a risk that the adoption of such a statement might still be reliant on external (non-government) efforts. Globally, it has been reported that the integration of IYCF-E policies within national policies is a gap (Gupta et al.). For the case of Lebanon, this gap exists and it is important to explore integration of IYCF-E policy within existing emergency plans.

There are no IYCF-E preparedness plans and no national IYCF or IYCF-E strategies - as also confirmed by IBFAN (2015) and reported in Chapter 4, Section 4.2. These gaps were highlighted at both the central level and service provision level where IYCF emergency

[47] Until the date of writing this report, the MoPH strategy did not have any provisions for IYCF-E in its emergency preparedness plans.

preparedness plans were neither documented nor acknowledged. There are emergency preparedness initiatives led by the Lebanese Red Cross and being piloted in few areas, however no IYCF messaging or plans are integrated within. While examining preparedness plans in the document review, no provisions for IYCF were identified. In inspecting the Lebanon Country Response Plan (GoL & UN, 2016), few IYCF indicators were there; however, this is not a national document and it is neither owned nor led by the government. It is led by UN agencies and NGOs. Therefore, at the time of writing, IYCF-E preparedness plans were led by international and UN organisations and were not part of a national initiative. Figure 8-1 below is a summary of findings in relation to existing IYCF-E policies.

It is important to note that in addition to a gap in IYCF-E policy content, gaps have been identified in relation to maternity protection policies as identified at both the central and service provision level.

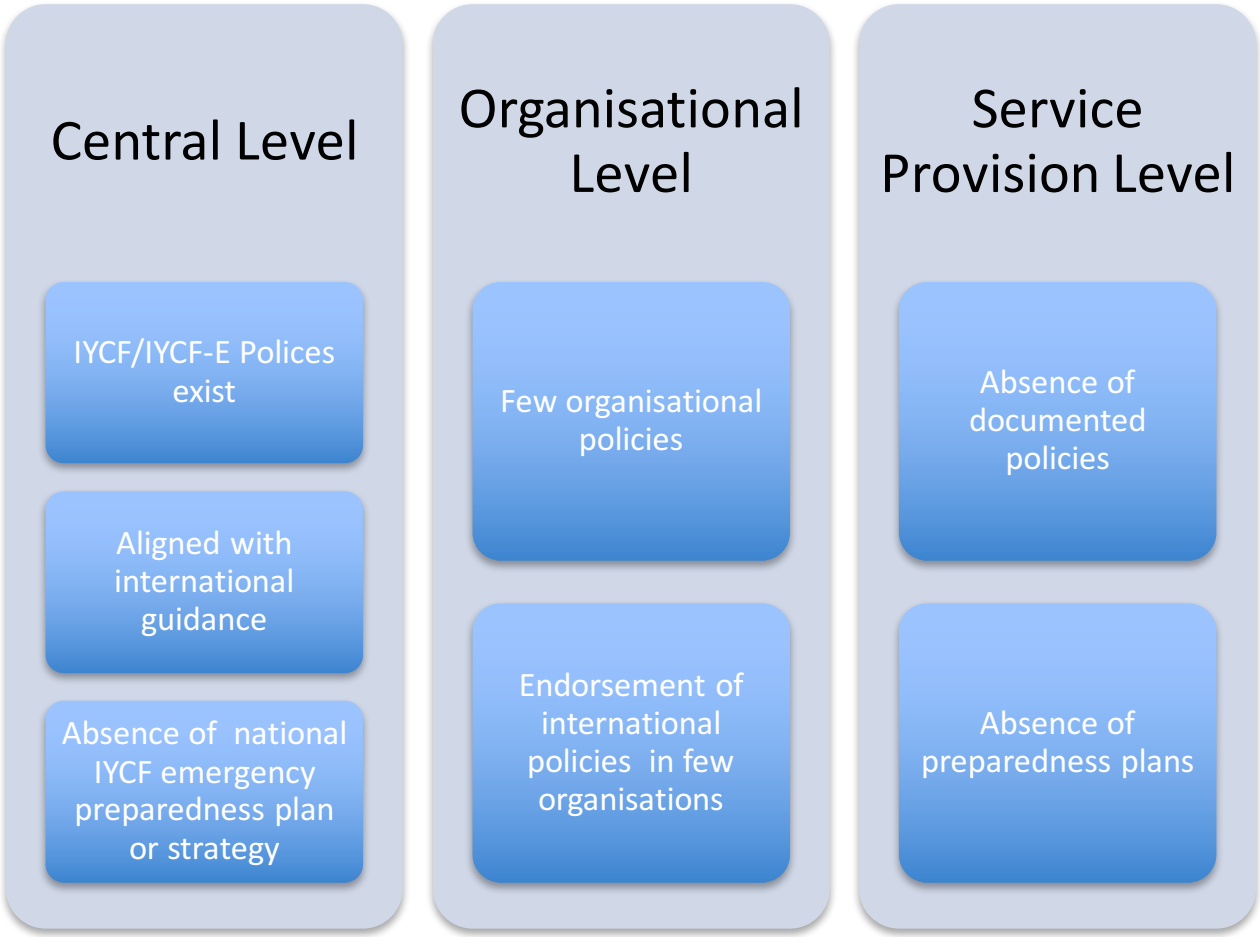

Figure 8-1 Convergence of findings related to IYCF-E content

Section 8.2 Implementation of Policies and Programmatic Activities

The second objective concerned the extent to which IYCF-E related policies and guidelines are implemented and translated into practice. The objective included an examination of policy implementation as well as programmatic activities.

Implementation of policies was evaluated by examining the extent to which policies were disseminated, endorsed, and respected. Findings showed a lack of awareness about the existence of such documents amongst key stakeholders, NGOs, and service providers

including Law 47/2008 and the joint statement. A lack of awareness about policies may be indicative of poor dissemination at the different levels. Recently, Akik et al. (2017), through a stakeholder policy analysis on IYCF in Lebanon, reported Law 47/2008 as "not being widely publicised in print media" which confirms gaps in dissemination.

Despite the lack of awareness about policy documents, knowledge about guidance within existing policies varied. A number of interviewees and service providers were not aware of guidance within those policies including their mode of operation. For example, there were gaps in knowledge about who is responsible for policy implementation and what their jurisdictions are. On the other hand, key stakeholders at the central level and HCPs at the service provision level were aware of the general rules and regulations surrounding IYCF – for example, mentioning the rule of forbidding the free distribution of infant formula.

The level of perceived implementation of existing policies varied from partial to none at both the central and service provision level with emphasis on improvement in implementation throughout the years. In practice, and in terms of direct *violations* to policies, this analysis showed that these were limited to NGOs. At the central level, no current free distribution of infant formula or other BMS was reported, although previous distributions of infant formula were noted by MoPH and another organisation. Also at the service provision level, none of the mothers reported receiving infant formula for free. This practice seems to have been recently adopted since previous distributions did

happen. Abiding by the policies does not seem to be as a result of the full enforcement of existing policies by the government. As noted by Akik et al. (2017) adherence may be due to external efforts such as those of NGOs and UN agencies which brings the subject of sustainability. It fact, IYCF-E policies were found to be better implemented than IYCF policies despite a non-official statement. Akik et al. reported Law 47/2008 was poorly enforced. Gaps remain both in terms of monitoring the distribution of artificial feeding and the provision of support for infants as discussed below.

In terms of programmatic activities and their alignment with national and international policies, first an *account of activitie*s and programmes was completed. While there are activities at the different levels, the analysis and triangulation of existing initiatives did not produce a clear construct. It was not easy to link programmes at the central level with those mentioned elsewhere - for example at the service provision level. At the central level, although stakeholders were often not aware of any existing initiatives, a number of programmatic activities were identified (Chapter 5, Section 5.1.1 'IYCF and IYCF-E policies and programmatic activities – content'). These mainly tackle nutrition and IYCF and have been found to be implemented by MoPH or NGOs. The few NGOs mentioned by key stakeholders to support IYCF-E were the same as those identified by the NGO questionnaire. These NGOs were also mentioned by HCPs at the service provision level (Chapter 7, Section 7.1 'Results from Focus Groups with Health Care Providers'). At the organisational level, there were also a number of activities that were identified as well as those identified through the document review (Chapters 4 and 6).

The nature of activities implemented focused primarily on awareness and staff capacity building and very few initiatives constituted a comprehensive IYCF programme. Reported activities seemed to be diluted moving from data collected through the document review (Chapter 4) to those collected at the service provision level (Chapter 7, Section 7.2 'Results from Focus Groups with Mothers'). For example, one-on-one support was reported as an implemented activity in the document review, whereas, it was very limited in findings from focus group with mothers. Artificial feeding support was lacking for non-breastfeeding mothers, with only one organisation providing artificial feeding support as recommended. Similar results were found at the institutional level. This is consistent with Dolan et al. (2015) as described in Chapter 6, Section 6.2 'Discussion of Findings at the Organisational Level' where gaps in IYCF-E interventions were reported in Lebanon including not addressing artificial feeding support. Overall, activities did not fully translate existing international guidance on IYCF-E support which combine promotion of appropriate IYCF practices as well as provision of support (Richardson & Walters, 2014; UNICEF, 2012; WHO, 2004).

Activities relied on external funding. At the central level, the work of the national committee established on IYCF, of which IYCF-E is a component, has been inconsistent and reliant on external funding (Akik et al., 2017). Similarly, most IYCF initiatives implemented by organisations have been reliant on external (UN and NGO) funding and support.

There is evidence to show that the MoPH is attempting to integrate nutrition activities within existing primary health services. However, IYCF activities were not included. As mentioned in Chapter 4, Section 4.1 'Global IYCF, IYCF-E Policies and Guidance', many of the IYCF programming guidance highlight the importance of integration of IYCF activities within existing services. As indicated in Shaker-Berbari et al. (2017), the modality of supporting nutrition programmes by NGOs had a shift in late 2015 when MoPH requested activities be integrated into existing primary health care services. However, IYCF was not prioritised and the only integration was related to treatment of acute malnutrition. Minor provisions were taken in order to integrate IYCF into those services.

Despite a perceived improvement in the implementation of IYCF policies, needed services are not translated to the end user (the mother). Mothers still experience lack of support and prevalent misconceptions potentially leading to sub-optimal feeding practices. Figure 8-2 is a schematic presentation of the convergence of findings related to programmes and policy implementation.

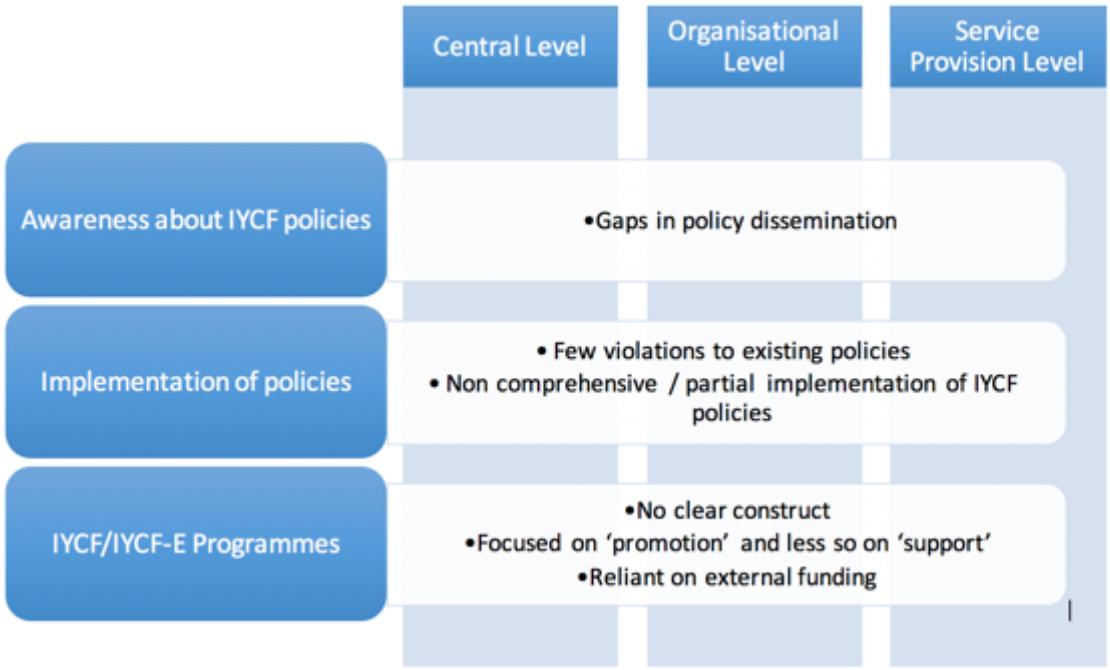

Figure 8-2 Convergence of findings related to IYCF/IYCF-E Programmes and Policies implementation

Section 8.3 Barriers for Implementation of IYCF-E Policies and Programmes

A number of barriers have been identified hindering the implementation of existing policies. Most of these barriers were identified and highlighted at the central level (Chapter 5 'IYCF-E Policies and Programmatic Activities – Findings at the Central Level') but were also related and often linked to the organisational and service provision level. These are summarised in Figure 5-1 and Figure 8-3.

8.3.1 Political will and prioritisation of IYCF policy implementation.

This analysis shows IYCF policy implementation is not prioritised and there are gaps in supporting IYCF at the national level and as a preparedness measure. The issue was mainly emphasised at the central level but also alluded to at the service provision level when service providers spoke about the importance of prioritising having a law. UNICEF (2013b) showed that one of the main reasons behind the lack of progress in breastfeeding in the world relates to gaps in political commitment and as a result, a framework was set out to galvanize stakeholders, including governments (WHO & UNICEF, 2015).

The lack of political will and prioritisation was linked to a *gap in evidence* in IYCF indicators or other health related indicators. This is also in line with findings from UNICEF (2013b) which showed failure to communicate the importance of breastfeeding is one of the main contributors to the low profile of breastfeeding. Interventions to protect, promote, and support IYCF practices have been shown to contribute to preventing child mortality (Black et al., 2008; Black et al., 2013). Such interventions are also considered investments in both the future health of children as well of the entire community (Rollins et al., 2016; Victora et al., 2016). It appears that this contribution is not evident within the context of Lebanon.

Other competing priorities are prevalent. MoPH priorities included NCDs because they are the number one cause of mortality in Lebanon in adults. NCDs have also been reported to be prevalent amongst Syrian refugees (Doocy et al., 2016). Breast cancer is another priority and MoPH conducts a yearly national campaign on breast cancer due to

the high rates of cancer (moph.gov.lb). The value of supporting IYCF is not evident given that there are no available indicators similar to the ones tied to NCDs. This is similar to the findings of Kirk et al. (2012), who evaluated the implementation of a breastfeeding policy in Nova Scotia in Canada and noted the lack of understanding about breastfeeding as a way to address childhood obesity. Providing evidence about the value of supporting IYCF may present as an opportunity to prioritise and support IYCF in Lebanon, as discussed in Section 8.4 'Plausible Approaches to Optimise IYCF-E'.

Another issue for the lack of prioritisation relates to gaps in data. There are no recent surveys that show the percentage of exclusive breastfeeding in Lebanon. The latest data are from 2009 (CAS & UNICEF, 2009), with no recent data available for assessing trends in breastfeeding in Lebanon. The recent national survey referred to in Chapter 2, Section 2.5 'Lebanon during the Refugee Crisis – Case Context' was not published and results remain preliminary (UNICEF, 2016a). As shown in Chapter 2, Section 2.2 'Infant and Young Child Feeding Trends and Issues', globally the trends in breastfeeding and infant feeding are improving but are still low. For Lebanon, the figure that is reported is from 2009 and does not show any progress, despite the work documented since then. Although individual studies continue to show different breastfeeding rates (Appendix 1), having a recent national survey could provide evidence about national trends in breastfeeding that incentivises support for IYCF at the central level.

Despite lack of prioritisation, there are indications of improvement and increased interest compared to before the Syrian crisis possibly due to external support. For example, a call for a consultancy was issued by UNICEF to assist the MoPH draft a policy for IYCF and a plan for the integration of IYCF within existing health structures (UNICEF, 2017). Therefore, it is evident that with the presence of external support, MoPH is willing to move forward to support IYCF. However, it seems that this will is not inherent and is often guided by the priorities of donors or NGOs due to availability of funding. The problem of funding remains an issue that many countries face in enforcement of IYCF policies (WHO & UNICEF, 2016).

8.3.2 The effect of marketing of infant formula on policy implementation and IYCF support.

The emphasis on the role that formula companies are playing at the central and service provision level is of concern especially because this impacts both service providers and policy makers. This is common in the sector of IYCF where lobbying and marketing by infant formula companies has been documented to influence IYCF policy implementation (WHO & UNICEF, 2015) and contribute to the low profile of breastfeeding (UNICEF, 2013b). This barrier has also been recently confirmed by Akik et al. (2017) as discussed in Chapter 7, Section 7.3.2 ‘Discussion of Findings at the Service Provision Level’.

The issue of inaccurate advice by health care professionals, namely doctors, as a result of marketing, demands further investigation and examination. It is concerning that if this is

happening, there is an urgent need to ensure doctors have clear instructions and that their actions have legal consequences. One must not disregard the possibility that HCPs, including doctors, might lack the capacity to provide adequate IYCF support as identified earlier (Chapter 7 'IYCF-E Policies and Programmatic Activities: Findings at the Service Provision Level') and reported by Akik et al. (2017). Therefore, providing inaccurate advice might not only be the result of infant formula marketing, it might also be due to the lack awareness and capacity to provide the right advice.

8.3.3 Structural barriers hindering implementation of policy.

Amidst the lack of integration and prioritisation of IYCF, structural barriers related to the actual feasibility of implementing existing policies emerge. These were highlighted at the central level but also witnessed at the service provision level. They included the multifaceted responsibilities for implementing policies with different ministries engaged, and even different departments within the same ministry. There is confusion and lack of awareness about responsibilities of and within ministries, despite this being mentioned in the Law. Although present, and as discussed in Section 8.2, policies are not well disseminated. The lack of human and financial resources to be able to monitor and implement the Law mentioned both at the central and institutional level is also a key structural barrier for implementation of policies. Akik et al. (2017) highlighted similar gaps and reported that despite commitment from the MoPH to support breastfeeding, the latter suffered from lack of financial and human capacity. For the joint statement, the lack of a legal framework seems to hinder the actual implementation. Addressing these

structural barriers presents an opportunity for furthering IYCF programming and support. However, it is still unclear whether it is the lack of awareness about these barriers amongst decision makers, the lack of prioritisation of IYCF, or even the effects of marketing of infant formula that is hindering these barriers from being addressed.

8.3.4 Lack of awareness and capacity for implementation of IYCF programmes.

Lack of capacity and awareness of service providers such as doctors and other HCPs, both at primary and secondary (*i.e.* hospital) levels, was identified as a barrier for provision of support. At the central level, these were seen as key to the provision of support for mothers. At the institutional level, the emphasis was on the lack of capacity and shortage of adequate staff. One of the main preparedness actions as indicated by the UNICEF programming guide and others is capacity building of service providers and the availability of a team of trained individuals to respond during emergencies (UNICEF, 2012). Gaps in capacity of human resources, including unavailability of specialists (except within the support of NGOs), are important to address.

Challenges related to mothers – the end user – were identified both at the central and service provision level, especially the latter. These consisted of a prevalent lack of awareness about IYCF (central and service provision level), challenging psychological state, poor eating habits, short gaps between pregnancies, poor breastfeeding practices and existence of misconceptions (service provision level). These prevalent factors contributed to poor IYCF practices. Amongst mothers, there was commitment to

breastfeed, although social, cultural and physical factors all affected the likelihood of success.

Figure 8-3 summarises the convergence of results related to gaps and barriers responding to objectives one, two, and three.

Figure 8-3 Convergence of results related to identified gaps and barriers for implementation of IYCF-E policies and programmes

Section 8.4 Plausible Approaches to Optimise IYCF-E

A final objective concerned identifying plausible approaches and opportunities to guide the development of effective IYCF-E policies and activities and address gaps and barriers identified in sections 8.1 to 8.3 (Figure 8-3). Suggestions were identified through participants' responses as well as the researcher's analysis of data and the literature. Particular literature was pulled into this section. For example, Akik et al. (2017) conducted a stakeholder analysis of breastfeeding policy implementation in Lebanon. They highlighted gaps and recommendations related to supporting IYCF in Lebanon. In addition, the BGM (Pérez-Escamilla et al., 2012) and the Alive & Thrive initiative (Baker, Sanghvi, Hajeebhoy, Martin, & Lapping, 2013; Hajeebhoy et al., 2013; Sanghvi et al., 2016) presented empirical evidence for scale up of IYCF programming that was useful for the contextualisation of findings from this study. The Breastfeeding Advocacy Initiative (WHO & UNICEF, 2015) and Pérez-Escamilla & Hall Moran (2016) also provide suggested steps for scale up of breastfeeding which have been drawn on while identifying possible opportunities in this study.

8.4.1 Opportunities to address lack of prioritisation and political will.

It is evident that addressing many of the gaps and barriers will require political will and the prioritisation of IYCF policy implementation (Figure 8-5). Akik et al. (2017) highlighted the importance of strong political will and commitment from the state to move IYCF policy implementation forward. The BGM indicates that political will forms an axis that is

necessary to drive the 'engine' forward (i.e. for other actions to follow such as implementation of policies) (Pérez-Escamilla et al., 2012).

One opportunity to ensure political will is presenting the evidence to decision makers about the importance and value of supporting IYCF. The BGM highlights that evidence based advocacy is necessary to ensure political will (Pérez-Escamilla et al., 2012). As suggested in the Breastfeeding Advocacy Initiative, promoting evidence including demonstrating the cost effectiveness of breastfeeding intervention is essential to "sway" decision makers to prioritise such initiatives (WHO & UNICEF, 2015). Providing such evidence presents a good opportunity for IYCF policy implementation and prioritisation amongst key policy makers in Lebanon.

The literature about the region provides evidence linking IYCF to a decrease onset of adult disease. Nasreddine et al. (2012) emphasised the need to improve IYCF and decrease the country's overall burden of disease. Nabulsi et al. (2014) established how supporting exclusive breastfeeding is a cost-effective public heath measure in a country with limited resources such as Lebanon. Other evidence can be drawn upon to further elevate the value of supporting IYCF in Lebanon. A review of literature about the importance of IYCF was presented in Chapter 2, Section 2.2 'Infant and Young Child Feeding Global Trends and Issues', and each of the health outcomes for adherence to recommended IYCF practices can serve as evidence for supporting it. Below are some key relevant linkages useful to build contextualised evidence on IYCF in Lebanon.

Evidence can be built to emphasise the importance of supporting IYCF in relation to its contribution to decreased adult onset disease. NCDs are considered the number one cause of mortality in Lebanon (MoPH, 2015a). There is evidence to show that early nutrition is linked to NCDs (Singhal, 2016) and that IYCF would contribute to preventing NCDs. The existing national NCD prevention strategy does not include any provisions for IYCF (RoL, MoPH, & WHO, 2016). Compiling evidence linking NCDs to early nutrition and demonstrating its effectiveness might serve as an incentive for MoPH to include IYCF within its NCD prevention plans.

Similarly, there is evidence of the value of supporting IYCF for the prevention of breast cancer (WCRF/AICR, 2017). Elias et al. (2016) showed that the cost of drugs provided by the MoPH was highest for breast cancer with a total of more than 60 million USD for around 50% of the population (10,000 beneficiaries). Although lack of breastfeeding is not the only factor associated with breast cancer, still, an increase of 5 months of lifetime breastfeeding was associated with a 2% reduction in breast cancer risk (Scoccianti et al., 2015). Evidence that an investment in supporting breastfeeding in Lebanon would likely offset some of the cost is important to present.

Other evidence that can be drawn includes contribution to mental health, control of infections, and growth and development. IYCF interventions, presented as a health investment, might serve as an incentive for the government to further prioritise it (WHO

& UNICEF, 2015) since restricted resources within the MoPH seems to be a factor hindering the prioritisation of IYCF. As for the example on breast cancer above, supporting IYCF has an impact on the cost of health expenditure in general (Renfrew et al., 2012; Rollins et al., 2016). At the same time, the costing of scaling up IYCF interventions is considered an important step that will provide a clearer image of the budget of an IYCF programme within the country (Pérez-Escamilla & Hall Moran, 2016).

Another opportunity that may contribute to prioritisation may be the support of a national survey on IYCF. In addition to providing evidence on the trend in IYCF practices, it is also important for the identification of factors that have contributed to the improvement or worsening of IYCF indicators (WHO & UNICEF, 2016).

In terms of opportunities for lobbying, the role of civil societies as well as academic institutions may be explored. The effect of civil societies on furthering breastfeeding in Lebanon has been documented by Akik et al. (2015) where a recently established organisation played a role in lobbying for the enforcement of Law 47/2008. Such potential champions have also been identified in this study. The concept of championing has been shown to contribute to the prioritisation of IYCF within governments and globally (WHO & UNICEF, 2016). Identifying potential champions amongst currently active actors would contribute to lobbying for the prioritisation of IYCF in Lebanon (Akik et al., 2017). At the same time, collaboration and coordination between governments, international

organisations, as highlighted by Pérez-Escamilla et al. (2012) is essential especially WHO and UNICEF given their mandate in relation to IYCF.

8.4.2 Opportunities to address gaps in policy content.

Opportunities have been identified to address gaps related to policy content as identified in Section 8.1. These include integrating the joint statement within existing emergency preparedness plans and having an integrative IYCF national strategy that includes provisions for IYCF-E. This was recommended by Puri et al., (2017) who conducted a policy content and stakeholder analysis for IYCF in India and identified gaps in IYCF-E policy guidelines. They suggested the development of IYCF-E policy guidelines that would be integrated within existing IYCF policies. It is actually important to consider the development of a national IYCF strategy that encompasses both emergencies and non-emergencies. Given that Lebanon does not have a comprehensive national IYCF strategy, such a strategy should contribute to ensuring recommended IYCF practices during non-emergencies and promote preparedness in emergencies.

Another opportunity that may aid in addressing gaps in policy content would be to include IYCF-E provisions within existing emergency preparedness plans. As presented in Chapter 4, Section 4.2 'IYCF and IYCF-E Policies, Guidance, and Programmes in Lebanon', emergency contingency plans do exist, but IYCF-E specifications are not taken into account. IYCF-E provisions may mean including guidance as per the joint statement. It may also encompass having contingency stocks of material essential for IYCF support as

suggested by key stakeholders (Chapter 5 'IYCF-E Policies and Programmatic Activities: Findings at the Central Level'). Gribble and Berry (2011) included guidance related to stock needed for the care of infants during emergency in developed countries. In addition, and in order to ensure sustainability of such provisions, it is important to formalise IYCF-E policies within a legal framework as it is the case of Law 47/2008. Provisions for maternity protection also need to be acknowledged.

8.4.3 Opportunities to address gaps in policy implementation.

Other than political will and prioritisation, structural barriers such as the lack of awareness about policies, their content, and mode of operation (i.e. jurisdictions of different parties and ministries), the poor enforcement, and monitoring of enforcement, are hindering the implementation of existing policies as also confirmed by Akik et al. (2017). Possible contextualised approaches to tackle such barriers have been considered.

One opportunity is the activation of the legal committee for the implementation of Law 47/2008 as mentioned in the Law document. With political support, the activation of such a committee would contribute to the enforcement of existing policies and the development of additional missing guidance. Karn, Devkota, Uddin, and Thow (2017) in a recent policy and stakeholder analysis on IYCF in Nepal, found that such a committee may include key actors to provide technical assistance. Key agencies engaged comprise UNICEF and WHO collaborating under the MoPH. If activated, such a committee may also

contribute to addressing gaps in the legal framework of policy implementation, setting up clear legal actions in response to policy violations.

Having standard operating procedures (SOPs) for the implementation of existing policies is another opportunity. Prior et al. (2014), while attempting to examined the implementation of NCD policies at the health care level, recommended that policies need to be translated into clear structured sets of activities in order for practice to be more organised and policy translated into practice. Mahmood et al. (2017), recently in an overview of IYCF policy in Pakistan, identified opportunities to strengthen IYCF policy by clarifying roles and responsibilities of different stakeholders. Puri et al. (2017) and Rasheed et al., (2017) also identified opportunities to strengthen policy in India and Bangladesh respectively by translating policies into implementation level documents. Solutions for the poor dissemination and awareness about such documents and the policies can be suggested, including the development of a capacity building and dissemination plan at the different levels.

Other practical aspects to investigate are the identification of a monitoring framework for the implementation of policies as also confirmed by Akik et al. (2017). Suggestions were made at the service provision and central levels to engage municipalities and casa doctors to contribute to the monitoring and enforcement of the Law. Such contextualised measures, and others that contribute to the operationalization of policies, are important to consider.

It is important to address the influence of infant formula companies. Having a policy that translates the Code is a main provision to offset this influence. Therefore, the approaches suggested above on policy enforcement are necessary to address this barrier. On the other hand, findings have hinted at the possibility of infant formula marketing affecting doctors' advice, and it is important to ensure that such actions are monitored and corrected. Akik et al. (2017) highlighted the importance of commitment from the side of health care professionals and suggested incorporating an accreditation system that could "pressure" doctors to abide by existing policies. The dissemination and establishment of policy guidance may contribute to offsetting such an influence by raising awareness and building capacity of doctors in relation to IYCF guidance and policies.

8.4.4 Opportunities to address gaps in programme implementation.

The lack of a clear construct of existing programmes and initiates and absence of a national IYCF strategy is important to address. A pre-perquisite for emergency preparedness lies in the scale up of IYCF interventions during non emergency situations (IFE-Core Group, 2007). It is therefore vital that to address gaps in programming, that IYCF programming in Lebanon be scaled up. Pérez-Escamilla and Hall Moran (2016) argue that failure to improve breastfeeding practices lies, in the "lack of conceptual clarity and evidence based frameworks" relevant to policy makers. There is therefore a need to ensure that a clear approach to IYCF programming is adopted. Having a comprehensive IYCF national strategy that encompasses provisions for IYCF-E may contribute to having a

clearer vision for IYCF support, both during emergencies and in normal situations. A strategy can address a number of gaps.

One gap is the lack of human capacity, emphasised at the central level and service provision level. This can be addressed by exploring context specific ways of integrating in-service and pre-service capacity building initiatives targeting HCPs in different disciplines, including physicians (Baker et al., 2013 and Hajeebhoy et al., 2013). The MoPH has recently launched a capacity development plan for HCPs at the primary health level (MoPH, 2017) and integrating IYCF messaging that is adapted to programmatic needs within such a plan may present one opportunity for dissemination as suggested in Senegal (Wuehler et al., 2011). Akik et al. (2017) suggested that the inclusion of the BFHI Ten Steps into health care accreditation standards provides an opportunity to improve capacity of human resources. At the same time, evaluating existing university curricula in relation to IYCF may contribute to the formation of a roster of capable health care professionals to overcome gaps in human capacity.

Suggested efforts such as capacity building will require investment in both human and financial terms. Given that a lack of financial resources may have hindered IYCF support, ensuring funding for such activities from external sources would seem to be essential. The prioritisation of IYCF and the development of a national strategy that requires resource mobilisation would contribute to furthering IYCF programmatic activities.

Approaches for improving the kinds of services provided were in line with IYCF guidance. Suggestions included provision of one-on-one support by skilled staff, providing awareness for mothers, providing mental health support and maternity protection. These recommendations were validated by mothers who emphasised mental health support, nutrition assistance, and counselling but also added in-kind and financial support. Awareness for mothers was cross cutting at the different levels/units of analysis. Empowering and building awareness for mothers was highly recommended as a key to ensuring adequate feeding practices. This was seen as a preparedness measure and a way to ensure mothers are equipped with the needed information to care for their children. Since 2015, the MoPH has been implementing national breastfeeding campaigns to raise awareness about breastfeeding. However, no formal process and outcome evaluation has been conducted. Implementing effective social marketing campaigns using behaviour change and communication techniques is important (Pérez-Escamilla & Hall Moran, 2016). Given that most of the support for these campaigns comes from external sources (UNICEF and INGOs), it is important that such activities are inherent within a national strategy to ensure sustainability.

Figure 8-4 is a presentation of the recommendations stemming from the different levels of analysis. Figure 8-5 provides a schematic presentation summarising opportunities and plausible approaches to guide the development of effective policies and programmatic activities.

Despite the identification of plausible approaches and opportunities, it is important to note that these warrant further exploration and testing. As previously remarked, evidence related to IYCF programming is emerging, however there is still a need to document plausible interventions in order to evaluate their impact and effectiveness. Examples of successful IYCF programmes include the Alive and Thrive initiative, which has been implemented in several countries and is reported to have several successful characteristics. These include an established national IYCF policy and strategy, coordination, interpersonal counselling, and social mobilisation amongst other factors (Baker et al., 2013; Sanghvi et al., 2016). Having the opportunity to document and evaluate possible interventions in Lebanon, building on existing evidence is worth exploring as a next step.

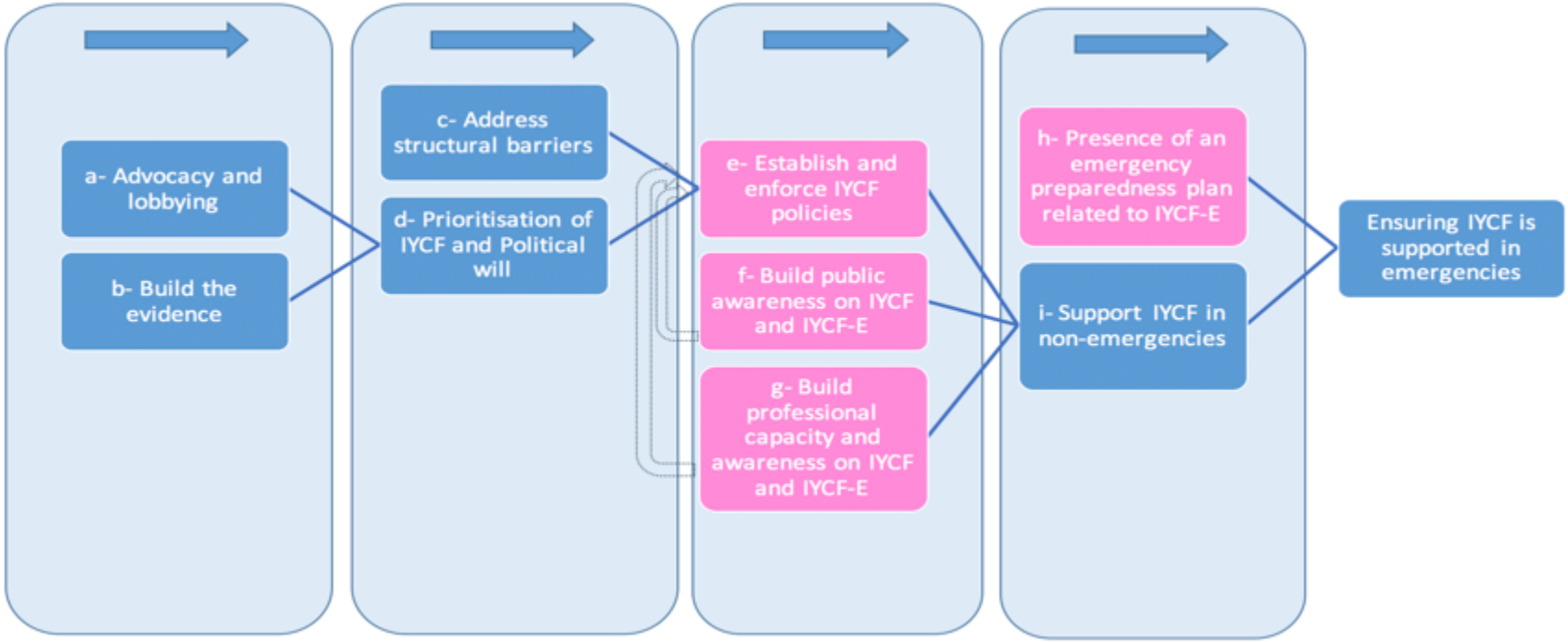

Figure 8-4 Convergence of results related to recommendations for supporting IYCF in emergencies (pink are those from both service provision level and central level, blue are those from the central level).

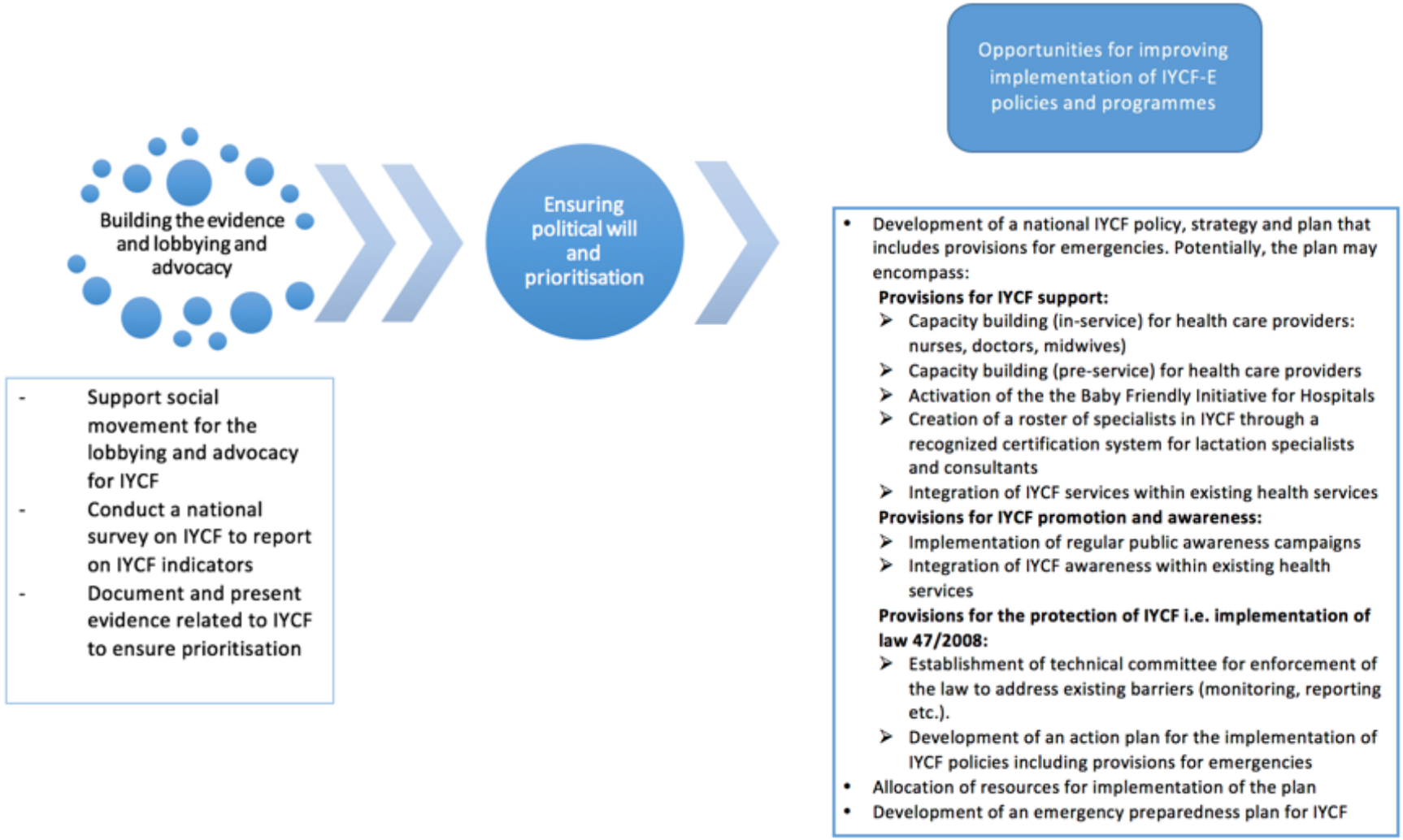

Figure 8-5 Opportunities and plausible approaches to guide the development of effective policies and programmatic activities

Section 8.5 Strengths and Limitations

The current research uses a single-case study with multiple units of analysis to address the research objectives. As discussed in Chapter 3 ('Methods and Methodology'), this methodology was chosen because of the depth of insight that it gives into the examined Case. Using the Case Study approach was of added value given that it allowed a thorough examination of IYCF-E policies and programmatic activities at the different levels of interventions. This methodology has given the research a breadth of information gathered at the three different levels and the opportunity to examine various perspectives. A main criticism for using Case Study methodology is replicability. A detailed account of the methods used is provided in Chapter 3 to provide sufficient details and allow the research to be repeated. However, as is the case in many qualitative and policy related research studies, especially in emergencies, the study is conducted in a particular dynamic environment and context - the Syrian refugee crisis in Lebanon. Therefore, it is unlikely that a repetition of the research in another period would generate exactly the same findings concerning the factors and status of policies and programmatic activities. However, what might be found is the progress within the Case and the extent to which there was evolution in the situation. In fact, the dynamic nature of the context by itself was a limitation. Within the Syrian crisis response, programming and planning were constantly evolving. In order to limit the influence of such changes, a time frame for data collection and reporting was set after which information was not included.

This research used a breadth of data collection methods and tools as recommended by Yin (2014) including a survey questionnaire, semi-structured interviews, and focus groups. This allowed the study to provide an in-depth exploration of the Case. On the other hand, all information collected was self reported and there was no opportunity to conduct observations to validate some of the reports by participants as also recommended by (Yin, 2014).

There are limitations in this research related to the recruitment of stakeholders, interviewees, and focus group participants. Although criteria were established for the selection of key stakeholders and a preliminary list was set, several intended interviewees were not available. For example, the DG at MoPH was not accessible; interviewing him could have given more insight into the feasibility of some of the plausible approaches and the gaps. At the same time, the PHCCs selected (comprising less than 4% of existing PHCCs and less than 1% of total primary health services in Lebanon) were those providing support to refugees, were accessible to the researcher, and willing to participate. Although not intended to be representative, given that these centres were accessible and available, it may be that they implemented more IYCF programmes. In fact, as mentioned in Chapter 2, Section 2.5, PHCCs providing services to refugees have received support as part of the response plan to refugees. This may mean that there might be over-reporting of the activities and that possibly other centres that are not part of the response have a lower level of policy and programme implementation.

Identifying participants within the HCP focus groups was difficult and presents as a study limitation. The researcher attempted to identify the position of each participant while speaking, however, given that the participants did not identify themselves every time they spoke, it was not possible to accompany all the quotes with the exact position the speaker held.

The recruitment of mothers was conducted in a way that rendered the role of the PHCC director crucial. It was him/her who allocated a member from the PHCC to invite mothers to come. This is both a strength and a limitation since mothers would trust an invitation from the centre given that is it a public health premise. At the same time, it is a limitation since the researcher had to rely on the efforts of the director to be able to disseminate the invitation. The PHCC director played a role of a gatekeeper and may have affected which mothers were invited.

Within findings at the organisational level, in relation to the distribution of infant formula, and as discussed in Chapter 6, Section 6.2 'Discussion of Finding at the Organisational Level', it is important to acknowledge the possibility of under-reporting by participants. The number, frequency, and quantity of infant formula distribution may have been different if the information was collected differently, for example via beneficiaries. On the other hand, this study required the collection of information related to policies and programmes which is necessary to receive from organisations themselves. In addition, findings from focus groups with mothers did not reveal that mothers received infant formula.

Another issue relates to the access to relevant and peer-reviewed literature on IYCF-E. Given that emergencies are difficult situations, there is often a shortage of empirical research within such contexts. This research has a strength that it was successfully implemented in a refugee and emergency setting. At the same time, it was often difficult to find relevant peer-reviewed research. In many cases, bulletins and field reports were the only available publications. Especially in relation to programme details, most of the information was collected from reports.

One limitation relates to the scope of the research and the extent to which the research encompassed IYCF comprehensively, i.e. breastfeeding and complementary feeding. Overall, the research focused more on breastfeeding than on complementary feeding although gaps in complementary feeding were identified within the refugee context in the literature review (Chapter 2; UNHCR et al., 2013; 2014; 2015; 2016). This was not intended, however findings from the different methods used did not reveal many outputs related to complementary feeding. In future similar research, it would be important to remind participants consistently that IYCF encompasses both breastfeeding and complementary feeding.

A particular strength of the study is the fact that it was able to cover different geographical areas. The research consisted of conducting focus groups with HCPs and mothers from the four regions in Lebanon. This was important to be able to represent the Case comprehensively.

One issue to acknowledge within this research, and as mentioned in Chapter 3 ('Methods and Methodology'), is how the identity of the researcher may have played a role in shaping the research. Recognising the role of researcher through reflexivity is important as it will ensure recognition of any potential subjective influence on the research and therefore increase the validity of the research (Finlay, 2002; Merriam, 2009). Reflexivity is the process of continuously engaging in self-reflection in order to generate awareness about the researcher's actions and perceptions (Darawsheh, 2014). The following is a construct of the reflexivity within this research where the researcher analyses subjective and intersubjective elements that may have influenced the research including potential limitations.

8.5.1 Role of the researcher.

Reflexivity starts when the researcher considers their position in relation to their research (Finlay, 2002) including their background, emotions and thoughts. I am a mother and I have lived during war times in Lebanon. I am aware of the difficult circumstances vulnerable populations go through during such circumstances and I am motivated to explore ways to ensure that the nutritional needs of infants and young children are met. I have been engaged in NGO work since 2002 and since 2010 my interest in IYCF led me to integrate IYCF programming into the work of the organisation I work in. This has given me knowledge and expertise in the field of infant and young child feeding. As the Syrian crisis started, I became more engaged in nutrition and IYCF programming targeting Syrian refugees and therefore programming in emergency situation. My technical knowledge in IYCF and engagement and

interaction in the field with different stakeholders had a lot of relevance in the different stages of the research.

First, my engagement in programming within the refugee situation in Lebanon was helpful in providing me with the opportunity to be aware of existing organisations and key stakeholders. However, on some occasions, given that I had previously interacted and met with some interviewees (key stakeholders), this may have encouraged interviewees to give the 'correct' answer – i.e. what they thought I wanted to hear. At the same time, this knowledge may also have encouraged them to be more frank, as I am 'one of them' and they know my background. My affiliation with an organisation that is engaged in IYCF might have also affected participants' attitude where it might be that they portrayed a better version of the situation than it is in order to please the interviewer. This potential desirability bias may be viewed as a limitation, however practicing reflexivity enabled me to gain awareness of such personal attributes (Darawsheh, 2014) and gave me the opportunity to control any subjectivity.

In addition, as I was conducting interviews with key stakeholders I was aware that a potential effect of my experience and knowledge in the field is the likely assumption on the part of interviewees that I know the answer. This may have affected the depth of the data or resulted in gaps in documentation (Rubin & Rubin, 2012). Although I may have pre-existing knowledge, this does not mean that this is the knowledge that will be provided or retrieved through the interviews. For example, while interviewing key stakeholders about existing policies, some may have assumed that I was aware of

the existence of Law 47/2008 given that I have previously mentioned the document within a different context.

As described in Chapter 3, section 3.3, and in order to address the effects of my identity, I clearly explained the study objectives and my role as a researcher both in the participant information sheet and orally. During the interviews, I limited my interaction to that of an interviewer. When asked about a technical question, I would postpone the answer until the research interview was over and would later respond. For example, in the focus groups with mothers, I was often asked questions about infant feeding or identified misconceptions. I would wait until the end of the interview and either address the questions to an available specialist or conduct myself a brief awareness session.

My experience in field work, was of relevance in the interviews and focus groups. Interviews require a set of communication skills including social interaction skills (Fylan, 2005; Rubin & Rubin, 2012) that I have acquired throughout my years of experience and this has facilitated the generation of data from interviews.

My familiarity with the context and culture was of added value. In some instances, mainly in the focus group meetings with mothers, I encountered an issue with translating some concepts verbatim from Arabic to English due to the difference in the meaning between English and the colloquial Arabic/Lebanese. Examples include the expressions “by God” which is often used by mothers to mean “truly”. Some mothers also spoke in the third person when referring to themselves. Being Lebanese with

colloquial Arabic/Lebanese as my mother dialect rendered the process easier since there is intimate knowledge of the culture and the language (Refer to Section 3.3.6, Chapter 2 'Translation of transcripts').

Finally, the difficulty in retrieving documentation about existing initiatives created a sense of frustration given that I was aware of certain programmes that were not documented in a retrievable or accessible manner. In fact, Yin (2014) highlighted that desk reviews conducted within case studies may present weaknesses such as lack of access or difficulty retrieving information. Particularly in relation to information about policies and activities, it was difficult to retrieve accurate and detailed information as it was mostly in the form of brief reports and articles.

Section 8.6 Study Implications

8.6.1 Policy and programmatic implications.

The study results have both policy and programmatic implications within Lebanon. Results are very timely given the refugee crisis and it is good to present plausible approaches to improve IYCF policy and programme implementation. It is also of value since the study results give insight onto improving preparedness for future emergencies. A number of possible opportunities were explored in this chapter which relate to both policies and programmes. In order to increase the chances that these recommendations are accounted for, efforts will be made to disseminate and share the findings of this research. For that, the author will organise a public information session for key stakeholders and policy makers. Members of the MoPH will be invited

as well as UNICEF and other stakeholders with the potential of playing a role in furthering IYCF and considering this research findings and recommendations. The fact that MoPH with UNICEF are partnering to design an IYCF strategy could be an opportunity to contribute to paving the road for improved IYCF policies and programmatic activities to ensure not only preparedness but also improved IYCF practices in Lebanon.

The study has potential implications for policy and programmatic activities within the Syrian refugee crisis as a whole. It comes to confirm the need to ensure preparedness in a country with low initial breastfeeding rates and with a high risk for emergencies. Many of the findings can be extrapolated to similar contexts such as Jordan, Iraq, and Syria. For example, in Jordan, a number of similar factors have been identified through a programme evaluation of activities on IYCF-E (Bassil et al., 2016). Findings showed the need to prioritise IYCF and lobby for the implementation of a national IYCF policy and the integration of IYCF within existing health services.

8.6.2 Research implications and future research.

This study highlights the importance of having an on IYCF-E policy and ensuring implementation. It sheds light on some of the factors that shape programming in IYCF in a middle income country hosting a large number of refugees using already debilitated services (Chapter 2, Section 2.5). It shows a gap in prioritising IYCF interventions and suggests ways to advocate for its advancement. This study confirms many of the issues highlighted in IYCF programming guides such as lack of preparedness, lack of capacity, and gaps in policy enforcement. It also, however,

identifies possible ways to overcome these barriers. The research suggests practical contextualised steps to move forward IYCF in a context such as Lebanon.

A series of research studies have attempted to evaluate the situation of IYCF policies and activities in different countries. In 2011, Wuehler led a series of situational analyses of IYCF policies and programmatic activities in Senegal, Chad, Niger, Mauritania, Mali, and Burkina Faso (Wuehler & Biga Hassoumi, 2011; Wuehler & Coulibaly, 2011; Wuehler & Hafel Ould Dehah, 2011; Wuehler & Nadjilem, 2011; Wuehler & Ouedraogo, 2011; Wuehler et al., 2011). More recently, the South Asia Infant Feeding Research Network also conducted three policy content analyses for IYCF in Nepal, Pakistan, Bangladesh, and India (Godakandage et al., 2017; Karn et al., 2017; Puri et al., 2017; Rasheed et al., 2017; Thow et al., 2017). Although adopting different methodologies, most of these analyses examine policies and opportunities for improvement for the support, promotion, and protection of IYCF similar to this research.

There is however still a need to examine the plausible approaches and opportunities in order to test their effectiveness and validity. A further measure would be to assess the effectiveness of opportunities and their feasibility. Despite the fact that this research engaged key policy makers, there is still a need to validate the findings with stakeholders with decision making powers. Prudhon et al. (2016) conducted a qualitative review of research priorities in relation to IYCF-E and concluded that one of the top ten research priorities related to existing and new interventions, the effect of IYCF-E interventions and their impact. In the case of this research, a future step is

to evaluate and document through empirical research recommended interventions in order to test their effectiveness and impact.

Section 8.7 Conclusion

This is the first Case Study to examine activities and services related to IYCF-E at the organisational and service provision level in Lebanon. The results are timely given the crisis situation Lebanon is facing but also the issuing of a new health strategy on the part of the MoPH. This research has contributed to understanding the barriers and issues related to supporting IYCF in emergencies and implementing policies from the perspective of different stakeholders at different levels. The findings from this research highlight the need to ensure that national policies, strategies and plans are in place in order to support IYCF and respond to emergencies in Lebanon. However, there is a need to further test and evaluate the best approaches for institutionalisation of services, and to establish what kind of programmatic activities work best. Moving forward, any initiative that will be implemented in the context of supporting IYCF will need to be monitored, evaluated and documented through rigorous implementation research.

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APPENDICES

LIST OF APPENDICES

Appendix 1

Annotated Bibliography on Feeding Practices in Lebanon

Appendix 1.1 List of Articles and Description

Title of the article	Date study was conducted	Objective/ research question	Kind of Study	Methods	Sampling	Sample	Sample size	Geographic coverage	Age	Data analysis	% of babies ever breastfed
Zurayk, H. C., & Shedid, H. E. (1981).	1976 & 1977	Look at changes in breastfeeding patterns in women living in rural areas. Look at factors related to women and affecting breastfeeding	Two surveys: retrospecti ve and prospective	Study includes two methods:1- Retrospective and Prospective survey	Stratified random sampling	Women aged 15 to 44 years of age.	1- n=1054 2- n=253	South of Lebanon (Urban and Rural)	0 - 18 months	Study compared rural vs. urban, and low vs. high education.	1- Retrospectiv e: 88.2% 2- Prospective study: 88%
Zurayk, H., Tawil, M., & Gangarosa, E. (1982).	1977	Assess the influence of maternal education and place of residence on patterns of reproduction, infant feeding, and use of health services.	Based on an 18-months prospective survey that started in 1977	18-months prospective survey	Households visited and women who had delivered live infants between March and June 1977 were interviewed.	Women who had delivered life infants between March and June 1977	n = 253 mothers	South Lebanon	0 -18 months	Study compared rural vs. urban, and low vs. high education.	N/A

Title of the article	Date study was conducted	Objective/ research question	Kind of Study	Methods	Sampling	Sample	Sample size	Geographic coverage	Age	Data analysis	% of babies ever breastfed
Central Administration of Statistics - MICS (2004)	2004	Provide detail on health, social, ecnomic, and environmental data to establish a national database. Provide health, demographic, and social indicators to monitor progress Raise awareness on issues related to repoductive health etc.	National Survey	Questionnaire (3 questionnaires)	Representative sample of Lebanese households	Lebanese households	n = 5532 households	National	0-35 months	Data entered and analysed on CsPro software Program	89%
Batal, M., & Boulghaurjian, C. (2005).	2003 - 2004	Study the impact of policies from the baby Friendly Hospital Initiative on breastfeeding initiation and duration. Examining attributes of breastfeeding initiation and duration.	Cross-sectional study	Questionnaire to asses trends of breastfeeding in Lebanon	1000 mothers and infants aged 1 to 5 years - Randomly recruited from Ministry of Social Affairs Health Centers	Mothers and infants aged 1 to 5 years	n = 830 mothers with children 1-5 years	Lebanon (6 provinces)	0-5 years	Cross tabulation (ChiSquare) and association (multivariate logistic regression)	95.40%

Title of the article	Date study was conducted	Objective/ research question	Kind of Study	Methods	Sampling	Sample	Sample size	Geographic coverage	Age	Data analysis	% of babies ever breastfed
Batal, M., Boulghourjian, C., Abdallah, A., & Afifi, R. (2006).	2003 - 2004	Look at the prevalence of breastfeeding and the factors associated with delivery, material SES and demographics. Look at the factors associated with initiation and duration of breastfeeding.	Cross-sectional study	Questionnaire - survey - included 9 sections	Two-stage sampling - random sample of health care centers from Ministry of Social Affairs.	Mothers who met the criteria of having last child between 1-5 years with gestational age 37 weeks or more	n = 830 mothers with children 1-5 years	Lebanon (See Batal 2005)	0 - 5 years	SPSS - Chi-square for cross tabulation	95.40%
Al-Sahab, B., Tamim, H., Mumtaz, G., Khawaja, M., Khogali, M., Afifi, R., et al. (2008).	Aug 2001 - Feb 2002	Assess the prevalence and predictors of breastfeeding at 1 and 4 months. Explore the role of the sex of the pediatrician using data from a prospective cohort project.	Prospective cohort - First Year of Life Follow Up Study	Questions administered by pediatricians - 7 questions + parental follow up by telephone 6 months after	Healthy infants (0-2 months) recruited through clinics and dispensaries of 117 pediatricians in Beirut and suburbs.	Inclusion criteria: Lebanese, single gestation, Bwt> 2.2, GA> 35 weeks, absence of anomalies, hospital birth, age @ 1st pediatrician visit 0-2 months + consent.	n= 1320 infants	Beirut and Suburbs	0 - 12 months	t tests, cross-tabulations, odds ratios, Logistic regression. SPSS.	N/A
Central Administration of Statistics - PAPFAM (2009)	2009	Survey to monitor progress towards MDGs	Survey	Questionnaires	Representative sample of Lebanese households	Lebanese households	n = 13575 households	National	0-35 months	Data analysed on Visual Basics, Oracle and SPSS	N/A

Title of the article	Date study was conducted	Objective/ research question	Kind of Study	Methods	Sampling	Sample	Sample size	Geographic coverage	Age	Data analysis	% of babies ever breastfed
Osman, H., El Zein, L., & Wick, L. (2009).	2007	Describe the cultural beliefs related to breastfeeding in first time moms as seen through calls to a hotline	Part of the "Hotline Utilization Study" - qualitative	Midwife answered calls and recorded on semi-structured data collection tool Hotline was available 4 months post delivery, 24 hours a day	Mothers recruited from 17 hospitals over 5 regions in Lebanon - Hospitals selected as having highest number of deliveries	Healthy first time moms, @ term - no complications.	n= 84 mothers	5 regions in Lebanon	0 - 4 months	Answers driven by algorithms developed by researcher for study. Data analyzed using framework approach for qualitative research	N/A
Batal, M., Boulghourjian, C., & Akik, C. (2010).	2003-2004	Identify patterns of introduction of solids and demographics, socioeconomic status and infant characteristics influencing practices and type of complementary foods provided to infants and young children	Cross sectional - survey	Food frequency questionnaire or frequencies of certain categories of food consumed by infants	1000 mothers and infants aged 1 to 5 years - Randomly recruited from Ministry of Social Affairs Health Centers	Mothers and infants aged 1 to 5 years	n = 830 mothers with children 1-5 years	Lebanon	0 - 5 years	Cross tabulation (ChiSquare) and association (multivariate logistic regression)	95.40%

Title of the article	Date study was conducted	Objective/ research question	Kind of Study	Methods	Sampling	Sample	Sample size	Geographic coverage	Age	Data analysis	% of babies ever breastfed
Nabulsi, M. (2011).	2007-2008	Explore maternal perceptions and experiences of BF moms using interviews over 1 year. Identify barriers and promoters of BF in the Lebanese context	Qualitative research - longitudinal	Focus group discussions and in depth interviews with mothers	Maternity wards of three hospitals serving communities with different SE, cultural, religious backgrounds. Theoretical sampling. Women delivering healthy live term newborns.	Women from three hospitals in Beirut, delivering healthy live term newborns	n = 36 mothers	Beirut	0 - 12 months	Transcripts of focus group analyzed using thematic analysis	86%

Appendix 1.2 Summary of Results from Articles Described in Appendix 1.1

Title of the article	Results				
	Initiation of breastfeeding	**Exclusive breastfeeding**	**Duration of breastfeeding**	**Factors affecting breastfeeding initiation**	**Factors affecting breastfeeding duration**
Zurayk, H. C., & Shedid, H. E. (1981).	N/A	N/A	Complete BF: 2.97 months (higher ed) - 7.55 months (illiterate) Parial BF: 4.73 months (higher ed) - 12.4 months (illiterate)	N/A	Misconception: lack of milk, pregnancy Education (higher ed) Area of residence (urban)
Zurayk, H., Tawil, M., & Gangarosa, E. (1982).	N/A	N/A	Wholly breastfed: 1.6 - 3.2 months Mixed feeding: 7.7. - 11.9 months	N/A	Place of residence Education in rural areas
Central Administration of Statistics - MICS (2004)	41.3% 1st hour after birth 17% 1-3 hours 15.1% 3-6 hrs 25.9% 6 hr+	24.5% 0-3 mths 7.6% 4-5 mths 2% 6-9 mths	Average breastfeeding = 9 mths	Order of the chld (3rd initated faster) Residents of the North and South (rural)	Education of the mother (illiterate breastfeed longer) Age of mother (younger mothers breastfeed longer)

Title of the article	Results				
	Initiation of breastfeeding	**Exclusive breastfeeding**	**Duration of breastfeeding**	**Factors affecting breastfeeding initiation**	**Factors affecting breastfeeding duration**
Batal, M., & Boulghaurjian, C. (2005).	First 1/2 hr: 18.3% Few hours: 55.9% Few days: 21.2%	N/A	41% of women stopped breastfeeding within 6 months or less	C-section delivery Baby brought to mother each 3 hrs or less and baby brought for night feeds	Employment Mother breastfed
Batal, M., Boulghourjian, C., Abdallah, A., & Afifi, R. (2006).	18.3% 1/2 hour, 55.9% few hours, and 21.2% a few days after delivery	52.4% EBF for 1 mth, 23.4% EBF for 4 mths, 10.1% EBF for 6 mths.	N/A	Type of delivery (C-Section) Hospital related factors (rooming-in, night feedings and frequency of mother–infant interaction)	Born in rural region Resident of rural region Lower educational level Pain killers

Title of the article	Results				
	Initiation of breastfeeding	**Exclusive breastfeeding**	**Duration of breastfeeding**	**Factors affecting breastfeeding initiation**	**Factors affecting breastfeeding duration**
Al-Sahab, B., Tamim, H., Mumtaz, G., Khawaja, M., Khogali, M., Afifi, R., et al. (2008).	N/A	Full breastfeeding* 56.3% @ 1 mth, 24.7% @ 4 mths, 18.8% @ 6 mths, 6.7% @ 12 mths	N/A	N/A	Pediatrician's sex (women) Working mother Religion (Muslim) Age (younger mothers)
Central Administration of Statistics - PAPFAM (2009)	N/A	EBF @ 6 mths = 2% EBF @ 0 -1 mth = 40% 14.8% of infants aged 0-5 mths were exclusively breastfed (Beirut and Mount Lebanon: EBF almost 0%)	Median duration of BF: 11-12 months BF @ 6-9 mths = 41.8% BF @ 12-15 mths = 37.5% BF @ 20-23 mths = 14.6%	Region: Beirut and Mount Lebanon (EBF almost 0%)	Education (primary and intermediate > university)
Osman, H., El Zein, L., & Wick, L. (2009).	N/A	N/A	N/A	N/A	Misconceptions: lack of milk, baby crying, belief in inability to breastfeed is inherited Using the pump: concern, afraid, evil eye Worrying about quality of the milk (cracks, meds, diet)

Title of the article	Results				
	Initiation of breastfeeding	**Exclusive breastfeeding**	**Duration of breastfeeding**	**Factors affecting breastfeeding initiation**	**Factors affecting breastfeeding duration**
Batal, M., Boulghourjian, C., & Akik, C. (2010).	18.3% 1/2 hour, 55.9% few hours, and 21.2% a few days after delivery	52.4% EBF for 1 mth, 23.4% EBF for 4 mths, 10.1% EBF for 6 mths.	N/A	N/A	Place of birth Place of residence (rural) Misconception: insufficient milk
Nabulsi, M. (2011).	N/A	N/A	35% for one year	N/A	Misconception: having bad or harmful milk, BF is painful, mother's milk is insufficient Work Maternal will and unselfishness

Appendix 2

Semi-structured Interviews Package

Appendix 2.1 Semi-structured Interviews Participant Information Sheet and Consent Form

Protecting the Vulnerable in Times of Vulnerability -
Linda Shaker – School of Nursing and Midwifery – University of Dundee
Participant Information Sheet
Stakeholder Interview

Introduction

I kindly invite you to participate in the **research study** titled "Protecting the Vulnerable in Times of Vulnerability". Before agreeing to participate in the research, it is important that you read the information below. This statement describes the purpose, procedures, benefits and description of the study. This also states your right to withdraw from the study at any time. Please feel free to ask any questions that you may have.

Purpose of the Research Study

This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations. Lebanon is prone to emergencies and feeding practices including breastfeeding fall short of the international recommendations. This research aims at conducting a situation analysis of the available policies and programmatic activities that tackle infant and young child feeding during emergency situations in Lebanon. The research includes interviews with key stakeholders involved in policy making and implementation, questionnaires to organizations involved in implementation of programs related to infant and young child nutrition, and interviews and focus groups with health care providers and mothers. Once data collection completed, the research will attempt to offer recommendations for improving infant and young child feeding policies at the national level.

The research is being conducted with the goal of publication in academic journals and presentation at academic conferences. Study results will likely be disseminated with relevant policymakers as well.

Description and Duration

In this study, you will be interviewed and asked to answer some questions related to the topic of infant and young child feeding during emergencies. The estimated time to complete this interview is approximately one hour. I will take notes of your answers and would also like to ask you if you would allow me to record the interview.

Termination of Participation and Recording
Your participation in this study is entirely voluntary. You may leave the study at any time and without having to give a reason. If you decide to stop participating, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with the University of Dundee.

We would like to record this interview so as to make sure that we remember accurately all the information you provide. All recordings will be stored in a password-protected computer. Information will only be used by the research team. You may still participate in the interview if you do not want the interview to be recorded. Recordings will be transcribed and will then be destroyed following transcription.

Risks, Discomforts and Benefits
Some of the questions I will ask you may bother you and you can choose not to answer them if you prefer. Your participation in this study does not involve any physical risk or emotional risk to you beyond the risks of daily life. You receive no direct benefits from participating in this research; however, your participation does help researchers shed light on available policies and programmatic activities as well as barriers and opportunities to improving policies related to infant and young child feeding during emergencies.

Confidentiality
All collected information will be solely used for the study and for no other reason or purpose. I will keep all your personal information confidential, and codes will be used instead of your names to ensure confidentiality. All codes and data will be kept in a password-protected computer that is kept secure. Data access is limited to the research team. All data will be stored and destroyed responsibly after the required retention period (usually three years) by Ms Linda Shaker. Your privacy will be maintained in all published and written data resulting from this study. Your name or other identifying information will not be used in our reports or published papers.

Dissemination of Findings
The results of this research will be written in the form of a dissertation and will be available at the Library of the University of Dundee. Findings may also be published in a peer-reviewed journal or presented at conferences. In all of these contexts, information will be presented in anonymous manner and anonymity of participants will be guaranteed at all time. In any of the publications, your names will not be used. The position will not be explicitly named but rather identified as senior position in the government or in an organization.

Contact Information and Questions
If you have any questions or feedback about the research, please do not hesitate to contact me. Once compiled, I will be happy to discuss the results of the research study with you. If you wish to participate in this study or if you have any further inquiries, please contact me:

Linda Shaker
By email: l.shaker@dundee.ac.uk By phone: 961-1-418430

Thank you for the time to read this information.
The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

Consent form

Study title: Protecting the Vulnerable in Times of Vulnerabilities – Infant and Young Child Feeding in Emergencies

This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations.

By signing below you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

		Yes	No
1.	I have read the information sheet that explains the reasons for this study [or have understood the verbal explanation] and I understand what is required.		
2.	I know that I am free to choose whether or not to participate in the study and I have been informed of the possibility to discontinue my participation at any time.		
3.	I agree for the interview to be digitally recorded.		
4.	I agree to the use of anonymous extracts from my interview in conference papers and academic publications		
5.	All the questions I had about this study have been answered.		

_____ _____

Participant's signature Date

_____

Participant's name

_____ _____

Signature of person obtaining consent Date

_____

Name of person obtaining consent

Appendix 2.2 Semi-structured Interview Guide

Protecting the Vulnerable in Times of Vulnerability – Infant and Young Child Feeding in

Emergencies - *Semi-structured interviews with Stakeholders – Interview Guide*

Acronym

IYCF-E	Infant and Young Child Feeding in Emergencies

Opening

Thank you, purpose, consent, and confidentiality.

Body

Topic 1:

General information about interview – please state your position or responsibility that you hold.

- Name of the position, years holding position
- Previous experience (history)
- Description of position and responsibilities

Topic 2:

Available policies and decrees on IYCF-E within institution that stakeholder represents or those that interviewee knows about

- Available policies and decrees that include infant and young child feeding guidance (include ANC, BFHI, WHO code/law)
- History about policies and decrees
- Description of policies and decrees (copies of decrees)

Topic 3:

Programs related to IYCF-E within institution that stakeholder represents or those that the interviewee knows about

- Available programs related to IYCF-E – focus on 2006 war and current interventions (Syria crisis)
- Name of programs, description and scope
- Entities responsible for executing programs

- Presence of hotline
- Management of donations / whether received donations and what was the action
- Extent to which IYCF is important during emergencies and extent to which stakeholder thinks it is a priority – elaborate on how priorities are set.

Topic 5:

Barriers and opportunities

- Barriers to implementing current laws and regulations related to IYCF-E
- Barriers and opportunities to implementing IYCF-E programs
- Best practices in IYCF-E
- Recommendations on best response in IYCF-E

Closing

Thank you and next steps – implications – follow up.

Appendix 2.3 Semi-structured Interview Questions and Translation

1. Can you please introduce yourself and the position you currently hold?	ممكن تعرف عن نفسك وعن المنصب يللي حضرتك شاغرو حاليا؟
2. Can you please provide me with a summary of your main responsibilities and a brief history on your work?	ممكن تعطيني ملخص صغير عن مسؤولياتك؟ و قديش صرلك بهذا المنصب؟
The first question relates to existing policies and laws on infant and young child feeding. 3. Can you please tell me if you are aware of any **policies or laws** related to infant and young child feeding either in your own institution or at the national level. Are you aware of such policies and law that relate to infant and young child feeding **in emergencies?** Policies could mean those related to hospitals, health centers or NGOs. What are these policies? When were they put? Can you provide a summary of the content? Would you share a copy if you have it?	اول سؤال هو عن السياسات والقوانين الموجودة حول تغذية الرضع وصغار الاطفال بحالات الطوارئ. فيك تخبرني اذا هناك سياسات محلية لدعم تغذية الرضع وصغار الاطفال بحالات الطوارئ؟ سياسات ممكن تكون تعنى بالمستشفيات المراكز الصحية، او الجمعيات شو هي هل سياسات؟ أي متى وضعت؟ ممكن اخذ نسخة عنها؟ ممكن تعطيني ملخص عن مضمونها؟
4. To what extent do you think are these policies **implemented**? 5. What are the **challenges** for implementation and **opportunities** for implementation? How could these policies and laws be implemented better? (recommendations) Divide between policies in *normal* situations and those specific to *emergencies*.	برأيك، هل تعتبر انو هذه السياسات مطبقة؟ شو هي التحديات الي عم بتواجه وعم بتأثر على تنفيذ السياسات؟ شو هي الطريقة للمساعدة في تطبيق السياسات؟
The second question is about **programs.** 6. Are you aware of programs either in your institution or elsewhere at the national level that support infant and young child feeding? (summary and reference) – mention currently or in the 2006 war. Are these programs **operational?** What are the **challenges** for implementation and **opportunities** for better implementation (focus on emergencies – example the 2006 war) What would contribute to improving implementation of these programs?	ثاني سؤال هو عن البرامج. هل هناك برامج دعم تغذية الرضع وصغار الاطفال في حالات الطوارئ؟ ممكن تلخصلي هذه البرامج، عنوانها و الشخص المسؤول عنها؟ (خلال الطوارئ السابقة (الحرب ٢٠٠٦ هل هناك برامج تنفذ حاليا من ضمن برنامج الاغاثة لدعم اللاجئين السوريين؟ هل يتم دعم الامهات المرضعات؟ هل يتم توزيع حليب للاطفال؟ هل البرامج شغالة؟ هل هناك تحديات تحول دون تنفيذ البرامج؟ شو اللي بيساعد البرامج انو تتنفذ احسن او بشكل سليم؟
7. In your opinion, what are **recommendations** for supporting infant and young child feeding in emergencies? How could we **better prepared** to respond to emergencies in terms of supporting IYCF?	ما هي التوصيات العامة لديك لدعم تغذية الرضع وصغار الاطفال في حالات الطوارئ؟ كيف فينا نكون محضرين لمواجهة الطوارئ من ناحية دعم تغذية الرضع وصغار الاطفال؟
8. How does your organization **prioritise** programs in emergencies? And are programs targeting infant and young child feeding a priority? (if not organization – personal opinion on national level).	هل تعتبر دعم تغذية الرضع وصغار الاطفال في حالات الطوارئ شيء مهم هل هو اولوية؟
9. Additional question: (if interviewee did not mention code or law or statement – introduce and ask whether he/she thinks these can be implemented, why yes, and why no and how could these be implemented)	سؤال اضافي: في حال لم يكن المستجيب يعرف عن القانون او الكود او النداء المشترك، السؤال شو هي التحديات الي ممكن تواجه في تنفيذ السياسات الموجودة – ممكن تتنفذ نعم او لا ولماذا ؟ شو هي الطريقة للمساعدة في تطبيق السياسات؟

Appendix 3

Survey Questionnaire - Content Validity Test

Appendix 3.1 Request for Content Validity Addressed to Members of the Infant Feeding in Emergencies Core Group

Protecting the Vulnerable in Times of Vulnerability -
Linda Shaker – School of Nursing and Midwifery – University of Dundee

Request to Review NGO Questionnaire - Content Validity

I am writing to kindly invite you to review my questionnaire developed as part of my **research study** titled "Protecting the Vulnerable in Times of Vulnerability".

Purpose of the Research Study
The study focuses on policies related to nutrition during the first two years of life especially during emergency situations. Lebanon is prone to emergencies and feeding practices including breastfeeding fall short of the international recommendations.

This research aims at conducting a situation analysis of the available policies and programmatic activities that tackle infant and young child feeding during emergency situations in Lebanon.

The objective of the research are:

1. To review and critically evaluate the content of current policies, practice based guidance, and programmatic activities related to IYCF in emergency situations in Lebanon with respect to concordance with international recommendations.
2. To identify and critically evaluate current implementation of policies and programmatic activities related to IYCF in emergency situations operational in Lebanon with respect to concordance with international recommendations.
3. To identify barriers to and opportunities for implementation of national and institutional policies and programs related to IYCF in emergency situations in Lebanon that comply with international standards.
4. To provide recommendations to guide the development of effective policies and programmatic activities that optimize IYCF in emergency situations in Lebanon.

The research includes interviews with key stakeholders involved in policy making and implementation, questionnaires to organizations involved in implementation of programs related

to infant and young child nutrition, and focus groups with health care providers and mothers. Once data collection completed, the research will attempt to offer recommendations for improving infant and young child feeding policies at the national level.

The research is being conducted with the goal of publication in academic journals and presentation at academic conferences. Study results will likely be disseminated with relevant policymakers as well.

Request for feedback

With this email, I am kindly writing to request that you fill out the attached form with feedback on clarity, content, approach, and relevance of each of the questions.

I ask you to please provide your feedback by and **before November 15, 2013**

Confidentiality
All provided information will be solely used for the study and for no other reason or purpose. Feedback that you provide will be used to improve on the questionnaire.

Dissemination of Findings
The results of this testing will serve to modify and amend the questionnaire in order to improve its content validity.

Contact Information and Questions
If you have any questions or feedback about the research, please do not hesitate to contact me. If you have any further inquiries, please contact me:

Linda Shaker Berbari
By email: l.shaker@dundee.ac.uk
By phone: 961-1-418430

Thank you for the time to read this information.

Returning feedback on the questionnaire indicate that you have read and understood the above information and that you have agreed to take part in the testing.

The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

Protecting the Vulnerable in Times of Vulnerability – Infant and Young Chid Feeding in Emergencies

Questionnaire Administered to Non-Governmental Organizations in Lebanon
Testing – Content Validity

Please rate each of the questions as to their Clarity, Content, Approach, and Relevance from 1 to 5, 1 being the least and 5 being the most.

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
Name of NGO: _____					
Type: (National, International, UN agency): _____					
Type of activity (sector) NGO is engaged in (please tick one or more):					
o Distribution of food items					
o Distribution of non-food items					
o Water, Sanitation and Hygiene (WASH)					
o Health					
o Reproductive health					
o Nutrition					
o Food security and livelihood					
o Education					
o Other: _____					
Organizational policy					

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
1. Does your organization have a written policy on infant and young child feeding?					
□ Yes, please go to Q1.1.					
□ No, please go to Q1.2					
□ I don't know, please skip to Q2					
1.1. If yes, would your organization share a copy of the policy?					
□ Yes					
□ No					
□ I don't know					
1.2. If no, does your organization endorse any written policies that specifically address infant and young child feeding?					
1.2.1. □ Yes, which one? Please specify title and reference: _____					
1.2.2. □ No, please go to Q2					
1.2.3. □ I don't know, please skip to Q2					
Programmatic activities					
2. Does your organization currently implement programs targeting (or in support of) lactating women, infants and young children?					
□ Yes, please continue.					
□ No, please skip to Q3					
□ I don't know, please skip to Q3					
2.1. If yes, what is the nature of the program?					
¨ Distribution of relief items					
¨ Support for primary health care					

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
¨ Health awareness					
¨ Capacity building					
¨ Other (please specify): _____					
2.2. If yes, please provide a summary of your program (objective, target, brief description of activities)					
3. Does your organization have a system or program designed to protect, promote and/or support infant and young child feeding?					
□ Yes, please continue.					
□ No, please skip to Q4					
□ I don't know, please skip to Q4					
3.1. If yes, please provide a summary of your program (objective, target, brief description of activities)					
Specific activities					
During the past or current emergency,					
4. Did your organization receive any infant formula donations?					
□ Yes, please continue.					
□ No, please skip to Q5					
□ I don't know, please skip to Q5					
4.1. If yes, what did your organization do with the donation (check all that apply)?					
¨ Distribute to infants within the general distribution					
¨ Donate to MOPH					

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
¨ Distribute to families of non-breastfed infants					
¨ Nothing/destroyed					
¨ Other (please specify): _____					
5. Did your organization distribute infant formula to families with infants less than 6 months of age?					
□ Yes, please continue.					
□ No, please skip to Q6					
□ I don't know, please skip to Q6					
5.1. In the past 6 months, to how many families did your organization distribute infant formula to? _____					
5.2. How were children identified as needing infant formula?					
□ Lists of families with children under 6 months were provided by municipalities or grass root organizations.					
□ Lists of families with children under 6 months needing infant formula were provided through an assessment conducted by your organization.					
□ Children were assessed by health care professional and referred as needing infant formula					
□ I don't know					
□ Other (please specify): _____					
5.3. Where did your organization obtain the formula?					
□ Local market					

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
□ Purchased from abroad					
□ Donation from (please specify): _____					
□ Other organization (please specify) _____					
□ Others (please specify) _____					
5.4. Was the formula milk distributed labeled in Arabic?					
□ Yes					
□ No (please specify which language was the formula labeled in): _____					
□ I don't know					
5.5. Did the formula have a visible brand?					
□ Yes					
□ No, why? _____					
□ I don't know					
6. In the past 12 months, did your organization distribute powdered milk within a general or blanket distribution to families that are in need (refugees or internally displaced)?					
□ Yes, please proceed to Q6.1					
□ No, thank you.					
□ I don't know, thank you.					
6.1. How many families in total benefitted from the distribution of kits containing powdered milk in the past 12 months? _____					
Any additional comments?					

Question	*Clarity*	*Content*	*Approach*	*Relevance*	*Suggested changes - please indicate*
Thank you for completing this questionnaire!					
Completing and returning the questionnaire indicates that you have read and understood the Participant Information Sheet and that you have agreed to take part of the study					

Other Comments/Suggestions:	

Appendix 3.2 Results of Content Validity Test – Scores

Question	***Clarity***	***Content***	***Approach***	***Relevance***
	Average score			
Name of NGO: _____	**5.0**	**5.0**	**5.0**	5.0
Type: (National, International, UN agency): _____	**4.5**	**4.0**	**4.5**	5.0
Type of activity (sector) NGO is engaged in (please tick one or more):	**4.5**	**4.0**	**4.5**	5.0
o Distribution of food items	5.0	5.0	5.0	5.0
o Distribution of non-food items	4.5	5.0	5.0	5.0
o Water, Sanitation and Hygiene (WASH)	5.0	5.0	5.0	5.0
o Health	5.0	5.0	5.0	5.0
o Reproductive health	5.0	5.0	5.0	5.0
o Nutrition	5.0	5.0	5.0	5.0
o Food security and livelihood	5.0	5.0	5.0	5.0
o Education	5.0	5.0	5.0	5.0
o Other: _____	4.5	5.0	5.0	5.0
Organizational policy				
1. Does your organization have a written policy on infant and young child feeding?	4.0	5.0	5.0	5.0
□ Yes, please go to Q1.1.	5.0	5.0	5.0	5.0
□ No, please go to Q1.2	5.0	5.0	5.0	5.0

Question	*Clarity*	*Content*	*Approach*	*Relevance*
	Average score			
□ I don't know, please skip to Q2	5.0	5.0	5.0	5.0
1.1. If yes, would your organization share a copy of the policy?	4.5	4.0	5.0	5.0
□ Yes	5.0	5.0	5.0	5.0
□ No	5.0	5.0	5.0	5.0
□ I don't know	5.0	5.0	5.0	5.0
1.2. If no, does your organization endorse any written policies that specifically address infant and young child feeding?	4.0	5.0	5.0	5.0
1.2.1. □ Yes, which one? Please specify title and reference: _____	5.0	5.0	5.0	5.0
1.2.2. □ No, please go to Q2	5.0	5.0	5.0	5.0
1.2.3. □ I don't know, please skip to Q2	5.0	4.0	5.0	5.0
Programmatic activities				
2. Does your organization currently implement programs targeting (or in support of) lactating women, infants and young children?	4.5	4.0	5.0	5.0
□ Yes, please continue.	4.0	4.0	5.0	5.0
□ No, please skip to Q3	4.0	4.0	5.0	5.0
□ I don't know, please skip to Q3	4.0	4.0	5.0	5.0
2.1. If yes, what is the nature of the program?	4.0	4.0	3.0	5.0
¨ Distribution of relief items	5.0	5.0	5.0	5.0
¨ Support for primary health care	5.0	5.0	5.0	5.0

Question	*Clarity*	*Content*	*Approach*	*Relevance*
	Average score			
¨ Health awareness	4.0	4.0	5.0	5.0
¨ Capacity building	4.0	5.0	5.0	4.7
¨ Other (please specify): _____	5.0	5.0	5.0	5.0
2.2. If yes, please provide a summary of your program (objective, target, brief description of activities)	3.0	3.0	4.0	5.0
3. Does your organization have a system or program designed to protect, promote and/or support infant and young child feeding?	3.5	3.5	5.0	5.0
□ Yes, please continue.	4.0	4.0	5.0	5.0
□ No, please skip to Q4	4.0	4.0	5.0	5.0
□ I don't know, please skip to Q4	4.0	4.0	5.0	5.0
3.1. If yes, please provide a summary of your program (objective, target, brief description of activities)	3.0	4.0	4.5	5.0
Specific activities				
During the past or current emergency,	5.0	5.0	5.0	5.0
4. Did your organization receive any infant formula donations?	5.0	5.0	5.0	5.0
□ Yes, please continue.	4.5	4.5	5.0	5.0
□ No, please skip to Q5	4.5	4.5	5.0	5.0
□ I don't know, please skip to Q5	4.5	4.5	5.0	5.0
4.1. If yes, what did your organization do with the donation (check all that apply)?	5.0	5.0	5.0	5.0
¨ Distribute to infants within the general distribution	3.5	4.0	5.0	5.0

Question	*Clarity*	*Content*	*Approach*	*Relevance*
	Average score			
¨ Donate to MOPH	4.5	5.0	5.0	5.0
¨ Distribute to families of non-breastfed infants	4.5	4.5	5.0	5.0
¨ Nothing/destroyed	4.5	4.5	5.0	5.0
¨ Other (please specify): _____	5.0	5.0	5.0	5.0
5. Did your organization distribute infant formula to families with infants less than 6 months of age?	5.0	5.0	5.0	5.0
□ Yes, please continue.	4.5	4.5	5.0	5.0
□ No, please skip to Q6	4.5	4.5	5.0	5.0
□ I don't know, please skip to Q6	4.5	4.5	5.0	5.0
5.1. In the past 6 months, to how many families did your organization distribute infant formula to? _____	4.3	4.3	5.0	5.0
5.2. How were children identified as needing infant formula?	4.0	4.0	5.0	5.0
□ Lists of families with children under 6 months were provided by municipalities or grass root organizations.	4.5	4.5	5.0	5.0
□ Lists of families with children under 6 months needing infant formula were provided through an assessment conducted by your organization.	4.5	4.5	5.0	5.0
□ Children were assessed by health care professional and referred as needing infant formula	4.5	4.5	5.0	5.0
□ I don't know	5.0	5.0	5.0	5.0
□ Other (please specify): _____	5.0	5.0	5.0	5.0
5.3. Where did your organization obtain the formula?	4.5	4.5	5.0	5.0
□ Local market	4.5	4.5	5.0	5.0

Question	*Clarity*	*Content*	*Approach*	*Relevance*
	Average score			
□ Purchased from abroad	4.5	4.5	5.0	5.0
□ Donation from (please specify): _____	5.0	5.0	5.0	5.0
□ Other organization (please specify) _____	3.5	4.0	4.0	3.5
□ Others (please specify) _____	5.0	5.0	5.0	5.0
5.4. Was the formula milk distributed labeled in Arabic?	5.0	5.0	5.0	5.0
□ Yes	5.0	5.0	5.0	5.0
□ No (please specify which language was the formula labeled in): _____	5.0	5.0	5.0	5.0
□ I don't know	5.0	5.0	5.0	5.0
5.5. Did the formula have a visible brand?	4.5	4.5	5.0	5.0
□ Yes	5.0	5.0	5.0	5.0
□ No, why? _____	4.0	4.0	5.0	5.0
□ I don't know	5.0	5.0	5.0	5.0
6. In the past 12 months, did your organization distribute powdered milk within a general or blanket distribution to families that are in need (refugees or internally displaced)?				
□ Yes, please proceed to Q6.1	5.0	5.0	5.0	5.0
□ No, thank you.	5.0	5.0	5.0	5.0
□ I don't know, thank you.	5.0	5.0	5.0	5.0

Question	*Clarity*	*Content*	*Approach*	*Relevance*
	Average score			
6.1. How many families in total benefitted from the distribution of kits containing powdered milk in the past 12 months? _____	4.5	5.0	5.0	5.0
Any additional comments?				
Thank you for completing this questionnaire!				
Completing and returning the questionnaire indicates that you have read and understood the Participant Information Sheet and that you have agreed to take part of the study				

Appendix 3.3 Results of Content Validity Test – Suggestions

Question	*Suggested changes*
Name of NGO: _____	• Reviewer#5: UN agency is not an NGO. Suggested edit.
Type: (National, International, UN agency): _____	• Reviewer#1: Type of NGO: (National, International, UN agency), circle • Reviewer#5: You may want an 'other' category, as there may be others involved in distribution that are not usually involved, eg military or civil society group or general 'do-gooders'
Type of activity (sector) NGO is engaged in (please tick one or more):	• Reviewer#1: I would add: Please check all applicable activities • Reviewer#4: Activities don't necessarily equate with sectors. Maybe one or the other? Distribution of food items would come under FSL • Reviewer#5: IN question, you say 'that NGO is engaged in' but earlier you ask about whether a UN agency or not. So may be better to use 'agency' rather than NGO in all questions, eg type of activity your agency is engaged in.
o Distribution of food items	
o Distribution of non-food items	• Reviewer#5: Would you include emergency shelter activities in here too?
o Water, Sanitation and Hygiene (WASH)	
o Health	• Reviewer#5: May also have mental health, NCDs. Some agencies may not classify nutrition under health.
o Reproductive health	
o Nutrition	• Reviewer#1: Nutrition is a separate sector than health, suggest not putting it under health. Suggest under health adding PHC or MCH
o Food security and livelihood	

Question	*Suggested changes*
o Education	
o Other: _____	• Reviewer#4: Might suggest adding protection activities as a stand-alone category?
Organizational policy	
1. Does your organization have a written policy on infant and young child feeding?	• Reviewer#2: Are you interested in policies specific to emergencies or in any context? You may want to specify this. • Reviewer# 3: "Does your organization have a comprehensive and written policy on infant and young child feeding?"
□ Yes, please go to Q1.1.	
□ No, please go to Q1.2	
□ I don't know, please skip to Q2	
1.1. If yes, would your organization share a copy of the policy?	• Reviewer#1: Share with whom? Consider rewording: If yes, would your organization be willing to share a copy of the policy? • Reviewer#3: Are you asking them to share the policy with you? Maybe ask instead, "If yes, can this policy be shared with the study investigator?"
□ Yes	
□ No	
□ I don't know	
1.2. If no, does your organization endorse any written policies that specifically address infant and young child feeding?	• Reviewer#2: You mean policies developed/written by external parties? • Reviewer# 3: "If no, does your organization endorse any written policies that address any aspect of infant and young child feeding? • Reviewer#5: 'Endorse' may be quite an official term, you might capture more if you ask 'does your organization **recommend** any……

Question	*Suggested changes*
1.2.1. □ Yes, which one? Please specify title and reference: _____	
1.2.2. □ No, please go to Q2	
1.2.3. □ I don't know, please skip to Q2	• Reviewer#1: Why not use the same as 1.2.2 approach? I don't know, please go to Q2 instead of please skip to Q2. More consistent this way
Programmatic activities	
2. Does your organization currently implement programs targeting (or in support of) lactating women, infants and young children?	• Reviewer#1: Why not pregnant and lactating women, infants and young children? Also why not specify till what age for the young children such as infants and children up to 24 months of age • Reviewer#3: Should ask about pregnant women? • Reviewer#4: I'm wondering here if you also want to capture pregnant women? Given that IYCF-E sensitisation can start then
□ Yes, please continue.	• Reviewer#1: Yes, please continue to Q2.1
□ No, please skip to Q3	• Reviewer#1: No please go to Q3 (for consistency with what you had before)
□ I don't know, please skip to Q3	• Reviewer#1: Same as above
2.1. If yes, what is the nature of the program?	• Reviewer#1: If yes, what is the nature of your program that targets PLW and infants and young children (or children < 24 months);
¨ Distribution of relief items	• Reviewer#5: You may want to distinguish between food items and non-food items.
¨ Support for primary health care	
¨ Health awareness	• Reviewer#2: Health awareness can mean different things to people in my opinion – do you mean training, or messaging, social marketing?
¨ Capacity building	• Reviewer#2: CB of community? Of health workers who support PLW and children?

Question	*Suggested changes*
	• Reviewer#4: Capacity-building can be cross-cutting, i.e. it might be part of support to PHC or health awareness too
¨ Other (please specify): _____	• Reviewer#4: Would you want to have a specific category for IYCF-E activities (as this is mentioned in Q3)? A specific category for protection activities (particularly relating to young infants)? • Reviewer#5: May want to add another category on mental health
2.2. If yes, please provide a summary of your program (objective, target, brief description of activities)	• Reviewer#1: Are you looking for info on the relief item distribution for example or on how they are targeting PLW and infants under 24 months in that program? • Reviewer#5: May have more than one programme so allow them to elaborate on another sheet if that is the case?
3. Does your organization have a system or program designed to protect, promote and/or support infant and young child feeding?	• Reviewer#1 What do you mean by system? Also in 3.1 you call it a program. Also should the question focus on emergencies? Or just in general? • Reviewer#2: Do you mean internal processes that ensure all programs/interventions protect and support IYCF? I see that as being different from a program. You then go on in 3.1 to only refer to program….I suggest clarifying the language • Reviewer#4: Will it be clear to participants exactly what IYCF means? We saw in Southern Turkey that people have different conceptions of what it means. You may get a more detailed response if you break it down into activities relating to protection of IYCF-E, activities relating to promotion of IYCF-E and activities relating to support of IYCF-E • Reviewer#5: Are you looking to identify any programmes supporting artificial feeding in this question? There is a risk that agencies will only report programmes around breastfeeding or complementary feeding here. May be worth asking a separate question on whether they have any programmes that target non-breastfed infants or infants that use infant formula.
□ Yes, please continue.	• Reviewer#1: Yes, please continue to Q3.1

Question	*Suggested changes*
□ No, please skip to Q4	• Reviewer#1: Same comments as previous sections. Need to be consistent
□ I don't know, please skip to Q4	• Reviewer#1: Same as above
3.1. If yes, please provide a summary of your program (objective, target, brief description of activities)	• Reviewer#1: Are you looking for info on the relief item distribution for example or on the IYCF activity in that program? • Reviewer#2: See comments above under 3
Specific activities	
During the past or current emergency,	• Reviewer#1: So is all of the above IYCF in general and now you are focusing on emergency? If yes then at the start of the previous section you may want to add a line about that. • Reviewer#3: There is a possibility that an organisation might have had different experiences in different emergencies. If this is the case it would make it hard to answer the questions and analyse results. Is there a way of choosing a particular emergency or getting info on a series of emergencies (I think that the latter would work best)?
4. Did your organization receive any infant formula donations?	
□ Yes, please continue.	• Reviewer#1: Same comment as the other sections
□ No, please skip to Q5	• Reviewer#1: Same comment as the other sections
□ I don't know, please skip to Q5	• Reviewer#1: Same comment as the other sections
4.1. If yes, what did your organization do with the donation (check all that apply)?	
¨ Distribute to infants within the general distribution	• Reviewer#: Do you mean: distribute to all infants as part of a general food distribution? Or should we say: distribute to all families who have a baby?
¨ Donate to MOPH	
¨ Distribute to families of non-breastfed infants	• Reviewer#1: Distribute ONLY to families of non-breastfed infants

Question	*Suggested changes*
¨ Nothing/destroyed	• Reviewer#1: Should we separate nothing and destroyed? Also say destroyed the donated formula?
¨ Other (please specify): _____	• Reviewer#2: What about an option for targeted distribution to infants requiring it?
5. Did your organization distribute infant formula to families with infants less than 6 months of age?	• Reviewer#5: I am not clear of the objective of this question. This may have been appropriate or inappropriate distribution depending on the context. Could reword to something like, What age group did your organisation distribute infant formula to, and ask them to tick age catergories.
□ Yes, please continue.	
□ No, please skip to Q6	
□ I don't know, please skip to Q6	
5.1. In the past 6 months, to how many families did your organization distribute infant formula to? _____	Reviewer#4: This will capture number of families but there might also be multiple distributions per family • Reviewer#5: This question implies it is distributed at a household level (to families) rather than to infants. Suggest reword to how many infants did you…..
5.2. How were children identified as needing infant formula?	
□ Lists of families with children under 6 months were provided by municipalities or grass root organizations.	• Reviewer#1: In the first section of the questionnaire, you did not put the lists in separate cells, you had indented and used bullets. May want to consider same here for consistency • Reviewer#5: Leading question on age category, would exclude those who targeted infants over 6 months of age
□ Lists of families with children under 6 months needing infant formula were provided through an assessment conducted by your organization.	• Reviewer#5: Leading question on age category, would exclude those who targeted infants over 6 months of age
□ Children were assessed by health care professional and referred as needing infant formula	

Question	*Suggested changes*
□ I don't know	
□ Other (please specify): _____	
5.3. Where did your organization obtain the formula?	
□ Local market	
□ Purchased from abroad	
□ Donation from (please specify): _____	
□ Other organization (please specify) _____	• Reviewer#1: This question is really part of the one above. Not sure it needs to be a standalone • Reviewer#4: Need to specify whether this would also be a donation or otherwise?
□ Others (please specify) _____	
5.4. Was the formula milk distributed labeled in Arabic?	
□ Yes	
□ No (please specify which language was the formula labeled in): _____	
□ I don't know	
5.5. Did the formula have a visible brand?	
□ Yes	• Reviewer#1: Do we want to know which one?
□ No, why? _____	• Reviewer#1: Do we want to know if they took the brand name off or they received it this way?
□ I don't know	

Question	*Suggested changes*
6. In the past 12 months, did your organization distribute powdered milk within a general or blanket distribution to families that are in need (refugees or internally displaced)?	
□ Yes, please proceed to Q6.1	• Reviewer#1: Reviewer#1: Same issue as in other sections
□ No, thank you.	• Not sure why you have thank you here. It meant to me that I do not have any more questions to answer but in reality there are still questions to answer.
□ I don't know, thank you.	
6.1. How many families in total benefitted from the distribution of kits containing powdered milk in the past 12 months? _____	• Reviewer#1: Need to be consistent with above
Any additional comments?	
Thank you for completing this questionnaire!	
Completing and returning the questionnaire indicates that you have read and understood the Participant Information Sheet and that you have agreed to take part of the study	• Reviewer#1: Maybe you should put this at the start of the questionnaire

Appendix 4 Survey Questionnaire Package (Request for participation, Participant Information Sheet, Questionnaire)

Appendix 4.1 Sample e-mails (request for participation and thank you e-mail)

Subject: NGO questionnaire - Infant and Young Child Feeding in Emergencies - Lebanon

Dear Ms/Mr. X,

I am writing to kindly invite you to fill out the attached questionnaire developed as part of my **research study** titled "Protecting the Vulnerable in Times of Vulnerability – Infant and Young Child Feeding in Emergencies".

Please find in the link below details about the study and the questionnaire to be filled out. I would appreciate if you can fill out and submit the questionnaire before January 20, 2015.

https://docs.google.com/forms/d/e/1FAIpQLSdFm7HlyE0mp_wZchr2eXjvx2WZJ0orA8VSsd9uD41aEMkORw/viewform

The questionnaire should not take more than 10 minutes of your time.

I thank you in advance for your time!

Kind regards,

Linda Shaker Berbari
L.shaker@dundee.ac.uk
961-3-418430

Subject: Thank you – Re: NGO questionnaire - Infant and Young Child Feeding in Emergencies - Lebanon

Dear Ms/Mr. X,

Thank you for taking the time to fill out the questionnaire developed part of the research study titled “Protecting the Vulnerable in Times of Vulnerability – Infant and Young Child Feeding in Emergencies” on behalf of

As a follow up step, I am happy to share with you two main policy documents related to Infant and Young Child Feeding in Lebanon.

The first one is the law 47/2008 which lays out main policies related to the marketing of breast-milk substitutes and other infant feeding products. The second document is the joint statement on Infant and Young Child Feeding in Emergencies issued in 2012.

I hope you find these documents useful and, if you haven’t done so, consider adopting them as reference in your organization.

Best wishes,

Linda

Linda Shaker Berbari
L.shaker@dundee.ac.uk
961-3-418430

Protecting the Vulnerable in Times of Vulnerability
Participant Information Sheet
Organization Questionnaire

Introduction
This is to kindly invite your organization to participate in the **research study** titled "Protecting the Vulnerable in Times of Vulnerability". Before agreeing to participate in the research, it is important that you read the information below.

Purpose of the Research Study
This study focuses on policies related to nutrition during the first two years of life especially during emergency situations. It aims at conducting a situation analysis of the available policies and programmatic activities that tackle infant and young child feeding during emergency situations in Lebanon. The research includes 1) interviews with key stakeholders involved in policy making and implementation, 2) a questionnaire to organizations involved in implementation of programs related to infant and young child nutrition, and 3) interviews and focus groups with health care providers and mothers. Once data collection completed, the research will attempt to offer recommendations for improving infant and young child feeding policies at the national level.
The research is being conducted with the goal of publication in academic journals and presentation at academic conferences. Study results will likely be disseminated with relevant policymakers as well. Study results from some questions in the questionnaire will also be used by UNICEF MENA regional office which is in the process collating information on infant formula distribution in an effort to strengthen the ongoing IYCF response to Syrian crisis.

Description and Duration
In this study, your organization will be asked to **fill out a questionnaire** that includes questions related to the topic of infant and young child feeding during emergencies. The estimated time to complete this questionnaire is approximately **15 minutes**. If you do not have the information, we ask you to please forward this information sheet to the relevant person and to please let us know who this person is. The person who would fill out the questionnaire should be the either the Relief Coordinator, Program Coordinator, Programs Manager, or Country representative. Persons filling out the questionnaires should be directly involved and in charge of relief activities in the organization.

Termination of Participation and Recording
Your organization's participation in this study is entirely voluntary. Your organization may choose not to fill out the questionnaire. If your organization decides not to participate, there will be no penalty, and the organization will not lose any benefits to which it is otherwise entitled. Your organization's decision will not affect your future relationship with the University of Dundee.

Risks, Discomforts and Benefits
Questions are straightforward and should not have risks or discomfort. Questions relate to your organization's activities. Your organization will not receive any direct benefits from participating in this research; however, your organization's participation does help researchers shed light on available policies and programmatic activities as well as barriers and opportunities to improving policies related to infant and young child feeding during emergencies.

Confidentiality
All collected information will be solely used for the study and for no other reason or purpose. We will keep all information confidential, and codes will be used instead of organizations' names to ensure confidentiality. All codes and data will be kept in a password protected computer that is kept secure. Data access is limited to the research team. All data will be stored and destroyed responsibly after the required retention period (usually three years). Your organization's privacy will be maintained in all published and written data resulting from this study. The names or other identifying information will not be used in our reports or published papers.

Dissemination of Findings
The results of this research will be written in the form of a dissertation and will be available at the Library of the University of Dundee. Findings may also be published in a peer-reviewed journal or presented at conferences. In all of these contexts, information will be presented in anonymous manner and anonymity of participants will be guaranteed at all time. Your name will not be mentioned in any of the publications.

Contact Information and Questions
If you have any questions or feedback about the research, please do not hesitate to contact me. Once compiled, I will be happy to discuss the results of the research study with you. If you wish to participate in this study or if you have any further inquiries, please contact me:

Linda Shaker
By email: l.shaker@dundee.ac.uk
By phone: 961-1-418430

Thank you for the time to read this information.

Completing and returning the questionnaire indicate that you have read and understood the Participant Information Sheet and that you have agreed to take part of the study

The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

حماية المستضعفين في أوقات الشدة
ليندا شاكر برباري جامعة داندي اسكتلندا
معلومات عن الدراسة والاستمارة

مقدمة
نتوجه لمؤسستكم الكريمة بدعوة للمشاركة في دراسة عنوانها "حماية المستضعفين في أوقات الشدة". قبل المشاركة في الدراسة من المهم قراءة المعلومات المدرجة أدناه.

هدف الدراسة

تركز هذه الدراسة على بحث السياسات و القوانين و البرامج المتعلقة بالتغذية خلال العامين الأولين من الحياة وخاصة في حالات الطوارئ واللاجئين.

تهدف الدراسة إلى إجراء تحليل لوضع السياسات الراهنة والبرامج والأنشطة التي تعالج تغذية الرضع وصغار الأطفال في حالات الطوارئ واللاجئين في لبنان.

تتضمن الدراسة ثلاث مراحل:
١ -مقابلات مع أصحاب الشأن الأساسيين المشاركين في وضع وتنفيذ سياسات وبرامج تعنى بتغذية الرضع وصغار الأطفال.
٢ -استمارات موجهة للجمعيات الغير حكومية المشاركة في تنفيذ برامج متعلقة بتغذية الرضع وصغار الأطفال.
٣ -مقابلات مع عاملين صحيين وامهات

عند الانتهاء من جمع المعلومات ستقدم الدراسة توصيات حول كيفية تطوير السياسات والبرامج المتعلقة بتغذية الرضع وصغار الأطفال على الصعيد الوطني.
كما ستستخدم نتائج الدراسة من قبل المكتب الإقليمي لليونسف وذلك لتعزيز برامج تغذية الرضع وصغار الأطفال.

شرح الاستمارة و مدتها

نطلب من جمعيتكم الكريمة خلال هذه الدراسة ملئ استمارة تتضمن أسئلة تتعلق بموضوع تغذية الرضع وصغار الأطفال في حالات الطوارئ. يتراوح الوقت المقدر لملء الاستمارة بين ١٠ ١٥ دقائق.

في حال لم يكن لديك المعلومات المناسبة يُرجى تحويل الاستمارة للشخص المناسب في الجمعية.
يجب على من يملأ الاستمارة أن يكون معنياً بأنشطة الإغاثة في الجمعية بشكل مباشر.

إنهاء المشاركة وحفظ المعلومات
مشاركة جمعيتكم الكريمة في هذه الدراسة هي مشاركة طوعية بشكل تام.
لجمعيتكم أن تختار عدم المشاركة وذلك لن يكون له أي تأثير على علاقة الجمعية بجامعة داندي.

فوائد و مخاطر الدراسة
أسئلة الاستمارة واضحة ولا تشكل أي خطر أو عدم راحة. الأسئلة بمجملها متعلقة بأنشطة الجمعية. إن مشاركة الجمعية في هذه الدراسة لن تعود على الجمعية بأية فائدة مباشرة ولكنها ستساعد على تسليط الضوء على السياسات المحلية والبرامج المتعلقة بتغذية الرضع وصغار الأطفال في حالات الطوارئ بالإضافة إلى الفرص المتاحة لتطوير هذه السياسات والبرامج.

خصوصية المشاركة
ستستخدم كل المعلومات التي يتم جمعها لغاية الدراسة بالإضافة لاستخدامها لتعزيز البرامج الجارية. جميع المعلومات ستبقى سرية وسيتم استخدام الرموز عوضاً عن الأسماء وذلك لضمان خصوصية المشاركين. ستحفظ كافة الرموز والبيانات في جهاز كمبيوتر محلي مزود بكلمة سر يتم الاحتفاظ بها آمنة لمدة ٣ سنوات ثم يتم تلفها.

نشر النتائج
سوف تكتب نتائج البحث بشكل أطروحة وستكون موجودة في مكتبة الجامعة. يمكن أيضا أن يتم نشر نتائج الدراسة في مجلات أكاديمية أو عرضها في مؤتمرات. سوف يكتب تقرير من قبل اليونسف وذلك لمشاركته مع الجمعيات المعنية. هذا بالإضافة إلى إمكانية مشاركة النتائج مع أخصائيين ومشاركين في وضع سياسات تعنى بتغذية الرضع وصغار الأطفال.

للمزيد من المعلومات
إذا كان لديكم أية أسئلة أو تعليقات حول الدراسة يرجى الاتصال بي:
عبر الهاتف: ٩٦١٣٤١٨٤٣٠
أو عبر البريد الكتروني: l.shaker@dundee.ac.uk

سيكون من دواعي سروري أن أناقش نتائج الدراسة معكم بعد انتهائها.

أشكركم على الوقت الذي خصصتموه لقراءة هذه المعلومات.
إن إكمال وإعادة الاستمارة يعني أنكم قد قرأتم ورقة المعلومات هذه ووافقتم على المشاركة في الدراسة.

لقد تم الموافقة على هذه الدراسة من قبل لجنة الأخلاق والبحوث في جامعة داندي.

Appendix 4.4 Survey Questionnaire

Available online:
https://docs.google.com/forms/d/e/1FAIpQLSdFm7HlyE0mp_wZchr2eXjvx2WZJ0orA8VSsd9uD41aEMkORw/viewform

NGO questionnaire - Infant and Young Child Feeding in Emergencies - Lebanon

Completing and returning the questionnaire indicate that you have read and understood the Participant Information Sheet and that you have agreed to take part of the study

The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

* Required

Please start below and thank you in advance for your time! *

- ( ) I would like to start with the questionnaire
- ( ) I prefer not to fill out the questionnaire

1- Name of Organisation *

2- Type of Organisation *

- ( ) National or Local Non Governmental Organisation
- ( ) International Non Governmental Organisation (INGO)
- ( ) UN Agency
- ( ) Other:

3- Location/Site where organisation is working *

Please click on all that apply

- [ ] National
- [ ] Bekaa
- [ ] Akkar
- [ ] Tripoli and/or surrounding (T5)
- [ ] Beirut/Mount Lebanon
- [ ] South
- [ ] Other:

4- Type of activity or sector organisation is engaged in *

Please click on all that apply

- [ ] Distribution of food items
- [ ] Distribution of non-food items
- [ ] WASH
- [ ] Health - Reproductive health
- [ ] Health - Nutrition
- [ ] Health - General
- [ ] Food Security and Livelihood
- [ ] Education
- [ ] Other:

5- Does your organisation have a comprehensive and written policy on infant and young child feeding (i.e. nutrition for children between 0 and 2 years of age)? *

- ○ Yes
- ○ No
- ○ I don't know

6- If your organisation has a written policy on infant and young child feeding, would your organization share a copy of the policy?

- ○ Yes
- ○ No
- ○ Not Applicable - our organisation does not have a written policy on infant and young child feeding

7- Does your organisation endorse any external written policy that address any aspect of infant and young child feeding such as the International Code of Marketing of Breastmilk Substitutes? *

- ○ Yes
- ○ No
- ○ I don't know

8- If your organisation endorses an external written policy on infant and young child feeding, please indicate which one:

Please specify title and reference

9- Does your organization currently implement programs targeting (or in support of) pregnant, lactating women, infants and young children? *

- ○ Yes
- ○ No
- ○ I don't know

10- If your organisation implements programs targeting pregnant, lactating women, infants and young children, what is the nature of the programs? *

Please check all that apply

- ☐ Distribution of relief items (food or non-food)
- ☐ Support for primary health
- ☐ Health awareness (education sessions)
- ☐ Capacity building (training)
- ☐ Not applicable. Our organisation does not implement program targeting lactating women, infants and children
- ☐ Other:

11- If your organisation implements programs targeting lactating women, infants and young children, please indicate the objectives of your program and list activities in the space below.
Please differentiate between programs in case there are more than one program

12- Does your organization have a system or program designed to protect, promote and support infant and young child feeding? (for example, does your organisation have a program that supports breastfeeding?) *
- ○ Yes
- ○ No
- ○ I don't know

13- During the current refugee/emergency crisis; did your organization ever receive any infant formula donations? *
- ○ Yes
- ○ No
- ○ I don't know

14- If your organisation received infant formula donations, what did your organisation do with the donation? *
Please check all that apply
- ☐ Distribute to infants within the general distribution
- ☐ Donate to MOPH
- ☐ Distribute ONLY to families of non-breastfed infants
- ☐ Nothing/destroyed
- ☐ Not applicable. My organisation never received a donation of infant formula during the current crisis
- ☐ Other:

15- If your organisation received infant formula donations, how many metric tons of infant formula has your organizations received?
Please put N/A if your organisation did not receive infant formula donations

16- During the current refugee/emergency crisis, did your organisation distribute any infant formula to families? *
- ○ Yes
- ○ No
- ○ I don't know

17- If your organisation distributed infant formula, to which age categories did your oganization distribute the formula? *
- ☐ Pre-term and low birth weight babies
- ☐ Infants 6-12 months
- ☐ Infants below 6 months
- ☐ Young children above 12 months
- ☐ Not applicable. Our organisation did not distribute any infant formula during the current crisis
- ☐ Other:

18- If your organisation distributed infant formula, how was for the formula distributed? *

- [ ] Mass/blanket distribution (in the general distribution)
- [ ] Only to selected mothers and infants
- [ ] Not applicable. Our organisation did not distribute any infant formula during the current crisis
- [ ] Other:

19- If your organisation distributed infant formula, how many families benefited from the distribution?

Please put N/A if question does not apply

20- If your organisation distributed infant formula, how many times per 6 months did your organisation conduct the distribution?

Please put N/A if question does not apply

21- If your organisation distributed infant formula, were infants/children assessed by a health professional before distribution? *

- ( ) Yes
- ( ) No
- ( ) I don't know
- ( ) Not applicable. Our organisation did not distribute any infant formula during the current crisis

22- If your organisation distributed infant formula, from where did your organization obtain the formula? *

- [ ] Purchased from local market
- [ ] Purchased from abroad
- [ ] Donated from another organization
- [ ] I don't know
- [ ] Not applicable. Our organisation did not distribute any infant formula during the current crisis

23- If your organisation distributed infant formula, how many cans of formula has your organisation distributed during the current refugee crisis?

Please put N/A if question does not apply

24- If your organisation distributed infant formula, was the formula milk labeled in Arabic? *

- ( ) Yes
- ( ) No
- ( ) I don't know
- ( ) Not applicable. Our organisation did not distribute any infant formula during the current crisis

25- If your organisation distributed infant formula, to your knowledge, did infant formula comply with the International Code of Marketing of Breast-Milk Substitutes (WHO)? *

- ( ) Yes
- ( ) No
- ( ) I don't know
- ( ) Not applicable. Our organisation did not distribute any infant formula during the current crisis

25- If your organisation distributed infant formula, to your knowledge, did infant formula comply with the International Code of Marketing of Breast-Milk Substitutes (WHO)? *

- Yes
- No
- I don't know
- Not applicable. Our organisation did not distribute any infant formula during the current crisis

26- If your organisation distributed infant formula, did the label display the brand name of the infant formula when distributed? *

- Yes
- No
- I don't know
- Not applicable. Our organisation did not distribute any infant formula during the current crisis

27- Is your organisation CURRENTLY distributing infant formula or any kind of milk? *

- Yes
- No
- I don't know

28- If your organisation CURRENTLY distributing infant formula or any kind of milk, for how long is your organisation planning on distributing the milk?

Please N/A if your organisation is not currently distributing infant formula or any kind of milk

29- During the current crisis, did your organisation ever distribute poweder milk alone or within the content of kits? *

- Yes
- No
- I don't know

30- If your organisation distributed powdered milk alone or within the content of kits, how many families benefited from the distribution? *

Please put N/A if your organisation did not distribute powdered milk

31- If your organisation distributed powdered milk alone or within the content of kits, how many times was the distribution done per 6 months?

Please put N/A if your organisation did not distribute powdered milk

Any other comments?

You're almost done! Please indicate your email address. The email address will only be used for tracking purposes within this research study. It will not be used for any marketing or promotion of any kind. *

Submit

Never submit passwords through Google Forms.

100%: You made it.

Appendix 5 Focus Group with Health Care Providers Package

Appendix 5.1 Focus Group with Health Care Providers Participant Information Sheet and Consent Form

Protecting the Vulnerable in Times of Vulnerability -
Linda Shaker – School of Nursing and Midwifery – University of Dundee
Participant Information Sheet
Focus Group Questionnaire – Primary Health Care provider

Introduction
I kindly invite you to participate in the **research study** titled "Protecting the Vulnerable in Times of Vulnerability". Before agreeing to participate in the research, it is important that you read the information below. This statement describes the purpose, procedures, benefits and description of the study. This also states your right to withdraw from the study at any time. Please feel free to ask any questions that you may have.

Purpose of the Research Study
This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations. Lebanon is prone to emergencies and feeding practices including breastfeeding fall short of the international recommendations. This research aims at conducting a situation analysis of the available policies and programmatic activities that tackle infant and young child feeding during emergency situations in Lebanon. The research includes interviews with key stakeholders involved in policy making and implementation, questionnaires to organizations involved in implementation of programs related to infant and young child nutrition, and interviews and focus groups with health care providers and mothers. Once data collection completed, the research will attempt to offer recommendations for improving infant and young child feeding policies at the national level.

The research is being conducted with the goal of publication in academic journals and presentation at academic conferences. Study results will likely be disseminated with relevant policymakers as well.

Description and Duration
In this study, you will participate in a focus group meeting where you and other participants will be asked to answer some questions related to the topic of infant and young child feeding during emergencies. The estimated time to complete this interview is approximately one hour. I will take notes of your answers and would also like to ask you if you would allow me to record the interview.

Termination of Participation and Recording

Your participation in this study is entirely voluntary. You may leave the study at any time and without having to give a reason. If you decide to stop participating, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with the University of Dundee.

We would like to record this focus group meeting so as to make sure that we remember accurately all the information you provide. All recordings will be stored in a password-protected computer. Information will only be used by the research team. Recordings will be transcribed will then be destroyed following transcription.

Risks, Discomforts and Benefits

Some of the questions I will ask you may bother you and you can choose not to answer them if you prefer. Your participation in this study does not involve any physical risk or emotional risk to you beyond the risks of daily life. You receive no direct benefits from participating in this research; however, your participation does help researchers shed light on available policies and programmatic activities as well as barriers and opportunities to improving policies related to infant and young child feeding during emergencies.

Confidentiality

All collected information will be solely used for the study and for no other reason or purpose. I will keep all your personal information confidential, and codes will be used instead of your names to ensure confidentiality. All codes and data will be kept in a password-protected computer that is kept secure. Data access is limited to the research team. All data will be stored and destroyed responsibly after the required retention period (usually three years) by Ms Linda Shaker. Your privacy will be maintained in all published and written data resulting from this study. Your name or other identifying information will not be used in our reports or published papers.

Dissemination of Findings

The results of this research will be written in the form of a dissertation and will be available at the Library of the University of Dundee. Findings may also be published in a peer-reviewed journal or presented at conferences. In all of these contexts, information will be presented in anonymous manner and anonymity of participants will be guaranteed at all time. In any of the publications, your names will not be used. The position will not be explicitly named but rather identified as senior position in the government or in an organization.

Contact Information and Questions

If you have any questions or feedback about the research, please do not hesitate to contact me. Once compiled, I will be happy to discuss the results of the research study with you. If you wish to participate in this study or if you have any further inquiries, please contact me:

Linda Shaker
By email: l.shaker@dundee.ac.uk
By phone: 961-1-418430

Thank you for the time to read this information.

The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

Consent form

Study title: Protecting the Vulnerable in Times of Vulnerabilities – Infant and Young Child Feeding in Emergencies

This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations.

By signing below you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

		Yes	No
1.	I have read the information sheet that explains the reasons for this study [or have understood the verbal explanation] and I understand what is required.		
2.	I know that I am free to choose whether or not to participate in the study and I have been informed of the possibility to discontinue my participation at any time.		
3.	I agree for the interview to be digitally recorded.		
4.	I agree to the use of anonymous extracts from my interview in conference papers and academic publications		
5.	All the questions I had about this study have been answered.		

_____ _____

Participant's signature Date

_____

Participant's name

_____ _____

Signature of person obtaining consent Date

_____

Name of person obtaining consent

Focus Group with Primary Health Care Providers
Topic Guide

Welcome and Introduction
Introduce research, purpose, and objectives. Thank participants for participating.
Obtain written consent and check approval for recording session.

Preamble:
Explain the process of the focus group discussion to participants. Explain that there is no right or wrong answer and that this is a conversation to explore issues and practices related to infant and young child feeding.

Go round the room and ask everyone to introduce themselves. Start with the researcher.

Questions:

1- **Are there any programs that you are implementing that target infants and young children including mothers with children under 2 years of age?**
Prompts: Awareness programs, distribution of assistance, distribution of micronutrients, other programs.

2- **What are those programs? how are they implemented and what are their components?**
Prompts: any partners implementing programs, is Ministry engaged, what do they consist of, etc.

3- **Are you aware of any policies and guidance related to Infant and Young Child Feeding?**
Prompts: in emergencies and in normal situations, local policies or international.

4- **Ideally, what should policies and guidance related to Infant and Young Child Feeding include?**
Prompts: what guidance, activities, restrictions, capacity building etc.

5- **What are in your opinion some of the challenges related to ensuring optimal infant and young child feeding especially during emergencies?**
Prompts: challenges related to staff, resources, target population, the situation etc.

6- **Scenario 1: A mother presents to your clinic, she is a Syrian refugee, she has an infant who is 2 months old, he is crying, he has diarrhea. She is asking to be provided with infant formula. How do you imagine the mother is feeling? what concerns might you have?**

7- **Scenario 2: A family visits the clinic, the family has 2 children one is 2 years and another is 8 months. The mother is still breastfeeding both children but the child who is 8 months is on exclusive breastfeeding. What concerns might you have? How would you suggest overcoming them?**

8- **Would anyone like to add anything else before we finish?**

Closure

Summarise discussions and recap the purpose.
Explain next steps.
Thank everyone for coming and participating in the study.
Make sure all consent forms are signed and provide participants with thank you token.

Appendix 6 Focus Group with Mothers Package

Appendix 6.1 Focus Group with Mothers Participant Information Sheet

Protecting the Vulnerable in Times of Vulnerability -
Linda Shaker – School of Nursing and Midwifery – University of Dundee
Participant Information Sheet
Focus Group Questionnaire – Mothers

Introduction
I kindly invite you to participate in the **research study** titled "Protecting the Vulnerable in Times of Vulnerability". Before agreeing to participate in the research, it is important that you read the information below. This statement describes the purpose, procedures, benefits and description of the study. This also states your right to withdraw from the study at any time. Please feel free to ask any questions that you may have.

Purpose of the Research Study
This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations. Lebanon is prone to emergencies and feeding practices including breastfeeding fall short of the international recommendations. This research aims at conducting a situation analysis of the available policies and programmatic activities that tackle infant and young child feeding during emergency situations in Lebanon. The research includes interviews with key stakeholders involved in policy making and implementation, questionnaires to organizations involved in implementation of programs related to infant and young child nutrition, and interviews and focus groups with health care providers and mothers. Once data collection completed, the research will attempt to offer recommendations for improving infant and young child feeding policies at the national level.

The research is being conducted with the goal of publication in academic journals and presentation at academic conferences. Study results will likely be disseminated with relevant policymakers as well.

Description and Duration
In this study, you will participate in a focus group meeting where you and other participants will be asked to answer some questions related to the topic of infant and young child feeding during emergencies. The estimated time to complete this interview is approximately one hour. I will take notes of your answers and would also like to ask you if you would allow me to record the interview.

Termination of Participation and Recording
Your participation in this study is entirely voluntary. You may leave the study at any time and without having to give a reason. If you decide to stop participating, there will be no penalty to you, and you will

not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with the University of Dundee.

We would like to record this focus group meeting so as to make sure that we remember accurately all the information you provide. All recordings will be stored in a password-protected computer. Information will only be used by the research team. Recordings will be transcribed will then be destroyed following transcription.

Risks, Discomforts and Benefits
Some of the questions I will ask you may bother you and you can choose not to answer them if you prefer. Your participation in this study does not involve any physical risk or emotional risk to you beyond the risks of daily life. You receive no direct benefits from participating in this research; however, your participation does help researchers shed light on available policies and programmatic activities as well as barriers and opportunities to improving policies related to infant and young child feeding during emergencies.

Confidentiality
All collected information will be solely used for the study and for no other reason or purpose. I will keep all your personal information confidential, and codes will be used instead of your names to ensure confidentiality. All codes and data will be kept in a password-protected computer that is kept secure. Data access is limited to the research team. All data will be stored and destroyed responsibly after the required retention period (usually three years) by Ms Linda Shaker. Your privacy will be maintained in all published and written data resulting from this study. Your name or other identifying information will not be used in our reports or published papers.

Dissemination of Findings
The results of this research will be written in the form of a dissertation and will be available at the Library of the University of Dundee. Findings may also be published in a peer-reviewed journal or presented at conferences. In all of these contexts, information will be presented in anonymous manner and anonymity of participants will be guaranteed at all time. In any of the publications, your names will not be used. The position will not be explicitly named but rather identified as senior position in the government or in an organization.

Contact Information and Questions
If you have any questions or feedback about the research, please do not hesitate to contact me. Once compiled, I will be happy to discuss the results of the research study with you. If you wish to participate in this study or if you have any further inquiries, please contact me:

Linda Shaker
By email: l.shaker@dundee.ac.uk
By phone: 961-1-418430

Thank you for the time to read this information.

The University of Dundee Research Ethics Committee (UREC) has reviewed and approved this study.

Consent form

Study title: Protecting the Vulnerable in Times of Vulnerabilities – Infant and Young Child Feeding in Emergencies

This study is part of a PhD study titled "Protecting the Vulnerable in Times of Vulnerability" which focuses on policies related to nutrition during the first two years of life especially during emergency situations.

By signing below you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

	Yes	No
1. I have read the information sheet that explains the reasons for this study [or have understood the verbal explanation] and I understand what is required.		
2. I know that I am free to choose whether or not to participate in the study and I have been informed of the possibility to discontinue my participation at any time.		
3. I agree for the interview to be digitally recorded.		
4. I agree to the use of anonymous extracts from my interview in conference papers and academic publications		
5. All the questions I had about this study have been answered.		

_____ _____
Participant's signature Date

_____
Participant's name

_____ _____
Signature of person obtaining consent Date

_____
Name of person obtaining consent

Appendix 6.2 Focus Group with Mothers Topic Guide

Focus Group with Mothers
Topic Guide

Welcome and Introduction
Introduce research, purpose, and objectives. Thank participants for participating.
Obtain written consent and check approval for recording session.
In case mother is illiterate, obtain verbal approval and record it.

Preamble:
Explain the process of the focus group discussion to participants. Explain that there is no right or wrong answer and that this is a conversation to explore issues and practices related to infant and young child feeding. Explain that if any point, mothers feel uncomfortable, they are free to leave the room. Encourage openness and communication when it comes to discomfort.
Go round the room and ask everyone to introduce themselves. Start with the researcher.

Questions:

1- **Since you arrived to Lebanon, have you received any assistance that would help you ensure proper feeding for your baby?**
Prompts: Awareness programs, distribution of assistance, distribution of micronutrients, other programs.

2- **Describe the assistance and how useful was it for you?**
Prompts: frequency, time, benefit, recommended or not.

3- **Ideally, what kind of assistance do you think you should be provided in order to ensure your infant or young child is well fed?**
Prompts: Guidance, food assistance, other assistance, medical care, house care, etc.

4- **What are in your opinion some of the challenges related to ensuring optimal infant and young child feeding especially during emergencies?**
Prompts: challenges related to staff, resources, target population, the situation etc.

5- **Can you give examples when you or other moms were adequately assisted? And other instances when they were not?**
   Prompts: Followed up by health care provider, provided with assistance, etc.

6- **Would anyone like to add anything else before we finish?**

Closure

Summarise discussions and recap the purpose.
Explain next steps.
Thank everyone for coming and participating in the study.
Make sure all consent forms are signed and provide participants with thank you token.

Appendix 7 Qualitative Data Analysis

Appendix 7.1 Sample Transcript Coding

Transcript #: SS05
Face to face interview
Date: April 23 2015

To your knowledge, what do we have in terms of policies or laws related to infant and young child feeding, be it in general or in emergencies?

Ok. We do have a law that regulates milk. Powdered milk, etc. and we have several ministerial decrees about baby friendly hospitals and banning bottle feeding, we have also a decree establishing breastfeeding program at the MopH with an NGO and I don't know the names of the decrees but we can get the text.

Linda Shaker Berbari
Mentioned existing policies:
-Law that regulates milk
-Ministerial decrees about BFHI
-Decree for establishing a program at MOPH with an NGO

How can I get a hold of them?

They should be on the ministry's website because any decree is already there.

Ok

Some of them date back to very old. Some of them are more recent. Some of them are updates.

Any policies specific to emergencies?

Yes, in 2006 there was a position paper collective. Headed by the ministry and all UN agencies involved about importance of breastfeeding and some child nutrition related issues.

Linda Shaker Berbari
Existing policies and guidance on IYCF in emergencies:
- Position paper head by MOPH and UN agencies

And this one, how can I get a hold of it

It's uuuh, copy in our archives. I need to get it for you. But it is already with the logos of everybody, UNICEF, WHO, UNFPA many people.

Ok

It was updated I think at the beginning of this crisis.

Linda Shaker Berbari
Exiting policies and guidance on IYCF in emergencies:
- position paper updated at the beginning of the Syria crisis

In terms of programmatic activities. Ongoing programs or previous programs. You mentioned the national program and the baby friendly hospital any other national programs that are ongoing.

The BFHI is working in hiccups. It works for a while and then people lose interest and then you have to reactivate it again and this has been ongoing for the past 20 years. There has been a lot of effort with the nurses, the midwives, you name it. It's not really full speed.

Linda Shaker Berbari
Existing programmes:
- BFHI

Anything specific to emergencies?

No

Linda Shaker Berbari
Existing programmes on IYCF-E:
- None

Except for the malnutrition screening that is going on now in the emergency with the [Name of NGO] supported by the humanitarian funds. They are screening the communities that are ... eh... that have the highest load of Syrian refugees and they are screening both Lebanese and Syrian children.

Linda Shaker Berbari
Existing programmes on IYCF-E:
- Nutrition screening with INGO

If I want to go back to policies. Are these laws decrees, implemented?

Look the powdered milk norms and standards fully implemented and inspected and everything. Now using bottled milk instead of breast milk is not well implemented.

Linda Shaker Berbari
Extent of law implementation:
- Partial – part related standards is fully implemented – part on distribution is not.

So, to what extent do you think the polices are implemented?

The law is not well implemented.

Linda Shaker Berbari
Extent of law implementation:
- not well implemented

The law?

Promoting bottled milk in hospitals is not implemented

Some hospitals out of their own interest and commitment do apply it but most of the hospitals don't

Linda Shaker Berbari
Extent of law implementation:
- Not implemented in hospitals

What about the position paper that was issued in 2006 and then re-issued, to what extent the humanitarian actors are abiding by it?

It is the basis of all infant and young children nutrition activities.

Do you think it is being fully implemented ?

It is fully promoted. But fully implemented there has been no real assessment done.

But definitely promoted. For sure.

Do you think there are challenges for implementing both the law and the position paper?

Yes

First of all, for the emergency you mean or regular.

For both

For both, the women are not compliant to exclusive breastfeeding because many are working and many need to send the children to nursery and it is very cumbersome to do the breast pumping all that. So compliance of the mothers.

You have encouragement of the powdered milk companies.

Marketing. It's very very aggressive. And it's well promoted.

So... also you have uh, there are no conducive environments for women who decide to breastfeed for 6 months at least and they have to work there are no private places, there are no equipment, where they can ensure that it can be done properly.

You have the medical doctors,

They are not all of them abiding by the recommendation of exclusive breastfeeding and they are not always abiding by the progressive introduction of solid food recommendations etc. so they come from different medical schools and medical thoughts.

So are they supportive of the mothers?

No, I think this is a big part of it. Because, you know, the doctor patient relationship is very strong in this country and if the doctor promotes then the woman would most likely do it.

Specifically in emergencies. What are the challenges for implementing the policies?

The challenges are in emergencies we are observing among the refugees extremes of age. Deliveries at extremes of age. So a young girl 16 – 17 may not be very familiar.

Ah extreme you mean young.

Extremely young or extremely old.

o, she needs to be coached for breastfeeding and encouraged and sometimes the mother is not there family support is not there. It's not very easy for her to start spontaneously. Sometimes they don't receive good counseling, antenatal, postnatal, they are not accompanied. Sometimes and many of the refugee women are doing daily work. Employment on daily basis so if they miss a day their income goes down and they have to work so it's financial issue and it's not easy to get a child with you to breastfeed every three hours.

Linda Shaker Berbari
The position paper is the basis of child nutrition activities within the Syria crisis

Linda Shaker Berbari
Extent to which position paper has been implemented:
-Fully promoted
- No data showing if fully implemented

Linda Shaker Berbari
Barriers to implementing policies and law:

- women are not compliant with breastfeeding – working and breastfeeding

Linda Shaker Berbari
Barriers to implementing policies and law:

-encouragement of infant formula companies
- marketing of infant formula
-lack of conducive environment (work, no private place, no equipment to ensure properly done)

Linda Shaker Berbari
Note:
Interviewee thinks that breastfeeding needs equipment and a lot of requirements

Linda Shaker Berbari
Barriers to implementing policies and law:
- Doctors not abiding by the breastfeeding recommendations or the introduction of solid foods – come from different schools of thoughts.

Linda Shaker Berbari
Barriers to implementing policies and law / supporting breastfeeding:
Doctors are a big part of the problem
-Value of the doctor /patient relation in Lebanon is very high – what doctor promotes – mother does – power of what the doctor says.

Linda Shaker Berbari
Challenges with IYCF in emergencies – specific to the refugee context:
- extremes of ages (very young or very old) not aware

Linda Shaker Berbari
Challenges with IYCF in emergencies – specific to the refugee context:
-mothers are not coached for breastfeeding – lack of awareness
-lack of support from the family
-lack of good counseling
-lack of antenatal care
-working mothers – missing a day affects income

Appendix 7.2 Coding Frames for Qualitative Data

Coding frame for analysis of stakeholder interviews

1. National and international policies on IYCF and IYCF-E
    - 1.1. Mentioned national and International policies on IYCF and IYCF-E
        - 1.1.1. Aware of policies - mention clear policies
            - 1.1.1.1. Law 47/ 2008
            - 1.1.1.2. 659 – Consumer protection law
        - 1.1.2. Aware of policies – not sure of the name
            - 1.1.2.1. MOPH policy
            - 1.1.2.2. Baby Friendly Hospital
            - 1.1.2.3. International policy
            - 1.1.2.4. Joint statement
        - 1.1.3. Not aware of policies
        - 1.1.4. Endorsing external policy but no national policy yet
    - 1.2. Extent to which existing policies are implemented
        - 1.2.1. Fully implemented
        - 1.2.2. Partially implemented
        - 1.2.3. Not implemented
    - 1.3. Barriers to implementing policies or reason for proper implementation
        - 1.3.1. No political will / not prioritised
            - 1.3.1.1. Lack of evidence that there is a need to work on the policy
            - 1.3.1.2. Not a priority
        - 1.3.2. Marketing of infant formula
        - 1.3.3. Structural barriers
            - 1.3.3.1. Different ministries involved
            - 1.3.3.2. Lack of awareness/dissemination
            - 1.3.3.3. Different department within ministries
            - 1.3.3.4. Lack of capacity / human resources
    - 1.4. Recommendations for better implementation of policy
        - 1.4.1. NGO support – NGOs to lobby for policy – NGOs to fund activities related to implementing policy
        - 1.4.2. Build professional capacity
        - 1.4.3. Build public awareness
        - 1.4.4. Political decision at the MOPH level / prioritise
        - 1.4.5. Focus on mothers – raise awareness of mothers

2. IYCF and IYCF-E initiatives and programmes

    - 2.1. Mentioned existing IYCF initiatives and programmes
        - 2.1.1. Not aware of any
        - 2.1.2. National Program for IYCF
        - 2.1.3. NGO programs
    - 2.2. Challenges in IYCF programming
    - 2.3. Recommendations to support IYCF
        - 2.3.1. Implement the law
        - 2.3.2. Focus on health care providers – capacity building
        - 2.3.3. Focus on educating mothers – empower mothers to ask for support
    - 2.4. Extent to which IYCF is a priority

2.4.1. High priority
2.4.2. Medium priority
2.4.3. Low priority
2.5. Reasons why IYCF is not a priority
2.5.1. Lack of data – evidence for the need to work on IYCF – infant mortality rate is low
2.5.2. Political decision – will
2.6. Recommendations to support prioritisation of IYCF
2.6.1. NGO support and lobby
2.6.2. Assessment/data to prove that IYCF is a gap in Lebanon
2.6.3. Political decision
2.7. Barriers to breastfeeding
2.7.1. Mothers' education
2.7.2. Health care staff education (doctors)

3. IYCF-E preparedness
3.1. Preparedness plans on IYCF
3.1.1. Existing plans – National response plan
3.1.1.1. National response plan at the council of ministers level
3.1.2. IYCF not included in National response plan or existing preparedness plans
3.2. Recommendations for IYCF-E preparedness
3.2.1. Implement the law
3.2.2. Work on IYCF in non-emergency settings
3.2.3. Develop standard operating procedures
3.2.4. Develop an emergency preparedness plan that includes IYCF
3.2.4.1. Include IYCF in preparedness plan at MOPH
3.2.4.2. Include IYCF in preparedness plan at municipality level
3.2.4.3. Engage casa doctors in preparedness plans
3.2.4.4. Work with PHCs
3.2.4.5. Build capacity of doctors
3.2.4.6. Include IYCF in preparedness plan at MOSA

Coding frame for analysis of focus groups with health care providers

1. IYCF and IYCF-E Policies, Programmatic Activities, and Capacity
    - 1.1. Institutional IYCF and IYCF-E policies
        - 1.1.1. IYCF or IYCF-E policies are not documented within primary health centres,
        - 1.1.2. Standards of practice
        - 1.1.3. Reference to existing policies such as the joint statement, the MoPH policy, the UNICEF policy and the institutional policy.
    - 1.2. Existing IYCF services and activities
        - 1.2.1. provision of awareness and education.
        - 1.2.2. ad-hoc basis counselling
        - 1.2.3. micronutrient supplementation.
        - 1.2.4. dependent on external assistance from a supportive organization.
    - 1.3. Emergency preparedness plans and capacity
        - 1.3.1. Received capacity building training sessions for staff focusing on IYCF through MoPH and external organisations.
        - 1.3.2. No written IYCF emergency preparedness plans.
    - 1.4. Implementation of existing IYCF policies
        - 1.4.1. Not enforced to enforced
            - 1.4.1.1. Lack of prioritisation
            - 1.4.1.2. Reported violations
2. Challenges in supporting IYCF
    - 2.1. Lack of professional and environmental support
        - 2.1.1. Lack of financial and human resources
        - 2.1.2. Conflict of interest
            - 2.1.2.1. Mothers face a number of challenges that need support
        - 2.1.3. Lack of capacity
    - 2.2. Barriers to breastfeeding related to mothers
        - 2.2.1. Maternal knowledge, education and skills,
        - 2.2.2. Stress,
        - 2.2.3. Nutrition, pregnancy, and malnutrition.
3. Recommendations for supporting IYCF
    - 3.1. Supporting mothers and children
        - 3.1.1. provision of one-on-one support
        - 3.1.2. awareness and education
        - 3.1.3. nutrition support (food and supplements)
        - 3.1.4. mental health support
        - 3.1.5. maternity protection
4. Recommendations for supporting IYCF in emergencies
    - 4.1. Supporting systems and communities
        - 4.1.1. Policy and strategy development
        - 4.1.2. Implementation of policies
        - 4.1.3. Capacity development
        - 4.1.4. Resource mobilization
        - 4.1.5. Government support
        - 4.1.6. Contingency stock of supplies

Coding frame for analysis of focus groups with mothers

1. Knowledge about optimal IYCF / practices
   - 1.1. Duration
   - 1.2. Importance of optimal IYCF / commitment to breastfeed

2. Services received
   - 2.1. No services received
   - 2.2. Micronutrient supplementation
   - 2.3. Awareness sessions
   - 2.4. Delivery / obstetrics services
   - 2.5. No - provision of artificial milk
   - 2.6. Mental health support
   - 2.7. Breastfeeding support
   - 2.8. Availability of adequate counselling - health care professionals provide poor advice

3. Feeding challenges expressed by mothers / practices
   - 3.1. Complementary feeding
     - 3.1.1. Picky eating / not eating
     - 3.1.2. Complementary feeding practices - focus on cereals and milk
     - 3.1.3. Complementary feeding - focus on fruits, vegetables and regular food
     - 3.1.4. Introduction of solids - early
     - 3.1.5. Introduction of solids - late
     - 3.1.6. Introduction of solids at 6 months
   - 3.2. Feeding challenges expressed by mothers - Breastfeeding practices
     - 3.2.1. No reported challenges
     - 3.2.2. Breastfeeding in initiation
     - 3.2.3. Breastfed then weaned - not enough milk
     - 3.2.4. Not enough milk - twins
     - 3.2.5. Weaned when came to Lebanon - lost the milk
     - 3.2.6. Stopped breastfeeding due to pregnancy
     - 3.2.7. Mother tired
     - 3.2.8. Mother hungry/nutrition affected
     - 3.2.9. Mental health and stress
     - 3.2.10. Pressure of the economic situation
     - 3.2.11. Fasting and breastfeeding
     - 3.2.12. Child did not gain weight so had to supplement
   - 3.3. Feeding challenges - children with special needs
   - 3.4. Perception of food security - satisfied

4. Other perceived challenges:
   - 4.1. Shortage of assistance - UN assistance causing food insecurity - not targeting properly (large families)
   - 4.2. assistance is acceptable but having to buy on a daily basis
5. Perceived needs - assistance needed
   - 5.1. Milk
   - 5.2. Diapers
   - 5.3. Nutrition for moms
   - 5.4. Medicine and health care
   - 5.5. Food for the family

6. Recommended services
    6.1. Family planning - contraceptives
    6.2. Hot meals/ready to eat meals for moms / families with children under 2
    6.3. Provide milk - artificial milk
    6.4. Improved living conditions
    6.5. Financial assistance
    6.6. Breastfeeding support

Appendix 8 Ethics Approval

Appendix 8.1 Ethics Approval Stage 1

Astrid Schloerscheidt School of nursing July 14, 2013 at 1:20 PM

Re: UREC 13077 -approved

To: Linda Shaker Cc: Astrid Schloerscheidt, Elizabeth Evans

Dear Linda,

many thanks for the revisions. Your study is approved.

Given that you intend to conduct work in Lebanon yourself (if I understood this correctly), could you please make sure you conduct a risk assessment. You can find information regarding this on the website of Health & Safety.

Best,

Astrid

On 10 Jul 2013, at 11:07, Linda Shaker wrote:

> Dear Dr. Astrid,
>
> Thank you very much for you input.
>
> Please find below my feedback on the points raised. I have added my name before each response.
>
> Also, attached please find a fully revised package. For documents that have been modified, I have dated the documents as rev July 10 and have highlighted the changes in blue. The other documents remain the same.
>
> I hope this is useful.
>
> I stand ready to provide you with any additional details.
>
> Looking forward to receiving your feedback.
>
> Thank you and best regards,
>
> Linda
>
> ---
>
> From: Astrid Schloerscheidt
> Sent: Tuesday, July 02, 2013 12:24 PM
> To: Linda Shaker
> Cc: Astrid Schloerscheidt
> Subject: UREC 13077
>
> Dear Linda,
>
> I have now had a chance to review your ethics application. My apologies for the slight delay in getting back to you.
>
> There are no ethical concerns regarding your study, but there is some further information that I require before I can approve your study.
>
> The information that I require concerns recruitment of participants. While you outline who you plan to interview or survey, you do not provide any detail on how you will approach these potential participants. I would need to see detailed information in the study protocol how you are going to deal with this: How you will provide the information sheet, how can participants let you know that they are interested and when and how you will obtain consent? This is particularly important in the case of the survey as the PIS suggests that you will be contacting an organisation rather than individuals. I you are asking the organisation to pass on the questionnaire to the relevant person, you need to detail this and consider whether there are any potential issues with coercion. This may be the case if you are contacting somebody who has line management power over the person you would like to fill in the survey.
>
> Linda: I have modified the project proposal to include the above mentioned information. In brief, in both interviews and questionnaires, participants will be sent an email with the PIS. For the interviews, a response and appointment of a date for the interview will be considered as agreement to meet. The consent form will be signed prior to the interview but on the same day of the interview. For the questionnaire, filling the questionnaire will be considered as consent. E-mails will be sent to the most relevant person, however, in case the relevant person does not have the information, then he/she will be asked to indicate the relevant person to whom the email will be sent again.
>
> Could you also please add information to the information sheet for the interviewees that the recordings will be transcribed and that the recordings will be destroyed following transcription.
>
> Linda: information added.
>
> I also have a question regarding anonymity of participants of interviews. Can I assume that you will not name the organisation and position of the person you interviewed in any publications? In my mind that appears the only way to protect identity and maintain anonymity of the data. I would be grateful if you could state this explicitly in the study protocol.
>
> Linda: Yes. I have already indicated that names of organisations or person interviewed will not be mentioned. I have added that the position will not be explicitly named but rather identified as senior position in the government or organisation.
>
> You can send the amended documents to me directly by email. I should then hopefully be in a position to approve your study soonest.
>
> Best regards,
>
> Astrid
>
> Dr. Astrid Schloerscheidt
> Chair, University of Dundee Ethics Committee
>
> <LShaker - PIS and Consent Form - Interview - rev July 10, 2013.docx><LShaker - Timescale - June 7, 2013 .xlsx><LShaker - Interview schedule - June 7, 2013.docx><LShaker - Project Proposal - UREC - rev July 10, 2013 .docx><LShaker - Questionnaire - June 7, 2013.docx><LShaker - UREC Application - June 7, 2013.doc><LShaker - PIS Questionnaire July 10, 2013.docx>

Appendix 8.2 Ethics Approval Stage 2

School of Psychology

University of Dundee Research Ethics Committee

Linda Shaker,
School of Nursing and Midwifery,
11 Airlie Place,
University of Dundee,
Dundee,
DD1 4HJ.

9 February 2015

Dear Ms Shaker,

Application Number: UREC 15004

Title: Protecting the Vulnerable in Times of Vulnerability - Infant and Young Child Feeding during Emergencies - Phase II.

Your application has been reviewed by the University Research Ethics Committee, and there are no ethical concerns with the proposed research. I am pleased to confirm that the above application has now been approved.

You submitted the following documents:

1. Annex 1 - Focus Group with PHCP Topic Guide
2. Annex 3 - Focus Group with Mothers Topic Guide
3. LShaker - UREC Application - December 19, 2014
4. Annex 2 - LShaker - PIS and Consent Form - Focus Group PHCP
5. Annex 4 - LShaker - PIS and Consent Form - Focus Group Mother
6. LShaker - Project Proposal STAGE II - UREC - Dec 19, 2014, 2014

Appendix 9 List of Available IYCF and IYCF-E Policies and Other Resources

Title	Organisation	Year	Online source
IYCF-E Policies			
UNHCR Policy Related to the Acceptance, Distribution, and Use of Milk Products in Refugee Settings.	UNHCR, ENN, IFE Core Group and the Institute of Child Health	2006	www.unhcr.org/uk/publications/operations/4507f7842/unhcr-policy-related-acceptance-distribution-use-milk-products-refugee.html
Operational Guidance on Infant and Young Child Feeding in Emergencies	IFE Core Group	2007	http://www.ennonline.net/operationalguidanceiycfv2.1
Milk Policy. World Vision	World Vision	2011	www.wvi.org/nutrition/publication/milk-policy
Humanitarian Charter and Minimum Standards in Humanitarian Response		2011	www.sphereproject.org/handbook
IYCF-E Position Paper. ILCA	ILCA	2014	http://waba.org.my/pdf/ilca-iycf-emergencies.pdf
IYCF-E Position Paper. ACF	ACF	2016	www.actionagainsthunger.org/publication/2016/02/infant-and-young-child-feeding-emergencies-iycf-e-position-paper-20
IYCF-E Position Paper. Save the Children	Save the Children	2016	https://drive.google.com/file/d/0B5uBNDhhrtqbNndidU91Ym1hNGM/view
Guiding Principles for Feeding Infants and Young Children During Emergencies.	WHO	2004	http://whqlibdoc.who.int/hq/2004/9241546069.pdf
UNHCR IYCF Practices: Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for Children 0-23 months.	UNHCR	2015	http://www.unhcr.org/55c474859.pdf
IYCF Policy (or related)			
The International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions (the Code)	WHO	1981	http://ibfan.org/the-full-code
Global Strategy for Infant and Young Child Feeding.	WHO and UNICEF	2003	www.who.int/nutrition/publications/infantfeeding/9241562218/en/
Guiding Principles for Complementary Feeding of the Breastfed Child.	PAHO and WHO	2003	www.who.int/nutrition/publications/guiding_principles_compfeeding_breastfed.pdf

Title	Organisation	Year	Online source
Guiding Principles for Feeding Non-Breastfed Children 6 – 24 months of age.	WHO	2005	www.who.int/maternal_child_adolescent/documents/9241593431/en/
Planning Guide for National Implementation of the Global Strategy for IYCF.	WHO and UNICEF	2007	www.who.int/maternal_child_adolescent/documents/9789241595193/en/
Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition.	WHO	2014	www.who.int/nutrition/publications/CIP_document/en/
Resource (training guide or programme guide)			
Breastfeeding Counselling: A Training Course.	UNICEF and WHO	1993	www.who.int/maternal_child_adolescent/documents/who_cdr_93_3/en/
Complementary Feeding Counselling: A Training Course.	WHO	2004	www.who.int/nutrition/publications/infantfeeding/9241546522/en/
IYCF Counselling: An Integrated Course.	UNICEF	2006	www.who.int/nutrition/publications/infantfeeding/9789241594745/en/
Infant Feeding in Emergencies Module 2 for Health and Nutrition Worker in Emergency Situations for Training, Practice and Reference. Version 1.1.	ENN and Collaborators	2007	www.ennonline.net/ifemodule2
Safe Preparation, Storage and Handling of Powdered Infant Formula: Guidelines.	WHO and FAO	2007	www.who.int/foodsafety/publications/micro/pif_guidelines.pdf
How to Prepare Formula for Cup Feeding at Home.	FAO and WHO	2007	www.who.int/foodsafety/publications/micro/PIF_Cup_en.pdf
Integration of IYCF Support into CMAM. ENN and IFE Core Group.	ENN and IFE Core Group	2009	www.ennonline.net/integrationiycfintocmam
IYCF-E Orientation Package.	ENN and IFE Core Group	2010	www.ennonline.net/iycfeorientationpackage
Harmonised Training Package (HTP) Module 17: IYCF. Version 2.	ENN and Nutrition Works	2011	http://www.ennonline.net/htpv2module17
IYCF Programming Guide.	UNICEF	2011	www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf
Combined Course on Growth Assessment and IYCF Counselling.	WHO	2012	www.who.int/nutrition/publications/infantfeeding/9789241504812/en/
The Community IYCF Counselling Package.	UNICEF	2013	https://www.unicef.org/nutrition/index_58362.html
The CDC Guide to Support Breastfeeding Mothers and Babies.	CDC	2013	www.cdc.gov/breastfeeding/pdf/bf-guide-508.pdf
Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency.	ACF	2014	www.actionagainsthunger.org/publication/2014/12/baby-friendly-spaces-technical-manual

Title	Organisation	Year	Online source
IYCF-E Guidance for Programming.	ECHO	2014	https://ec.europa.eu/echo/files/media/publications/2014/toolkit_nutrition_en.pdf
Care Groups: A Reference Guide for Practitioners.	TOPS, Food for the Hungry, CORE Group and World Relief	2016	www.fsnnetwork.org/care-groups-reference-guide-practitioners
IYCF-E Toolkit. Version 3. Save the Children, 2017.	Save the Children	2017	https://sites.google.com/site/stcehn/documents/iycf-e-toolkit-v3
The International Code of Marketing of Breast-milk Substitutes – 2017 Update. Frequently Asked Questions.	WHO	2017	www.who.int/nutrition/publications/infantfeeding/breastmilk-substitutes-FAQ2017/en/
Integrated Multi-Sectoral Infant and Young Child-Friendly Framework	UNHCR and Save the Children	2017	www.unhcr.org/nutrition-and-food-security
Programming for IYCF – a Training Course.	UNICEF and Cornell University		www.nutritionworks.cornell.edu/UNICEF/about/

Appendix 10 Law 47/2008

Republic of Lebanon
Parliament

Law No. 47 of 11/12/2008
Official Gazette No. 55 of 13/12/2008

Organizing the Marketing of Infant and Young Child Feeding Products and Tools

Content:

Chapter I: Common Provisions

Article 1: **Scope**

This Law entitled "Law Organizing the Marketing of Infant and Young Child Feeding Products and Tools" applies to designated products as defined in Article 3.

Article 2: **Aim**

This Law aims at providing safe and healthy food to infants and young children by protecting, promoting and supporting breastfeeding and ensuring safe use of infants and children food and complementary food products (when needed) according to adequate information, and providing the right information and educating parents and health workers about infant and young child health and nutrition through regulating the methods and practices of marketing and distribution to achieve this aim.

This Law encourages exclusive breastfeeding during the first six months of age, and adopting the adequate complementary food practices as of the age of six months; making sure breastfeeding is continued for not less than two years, as a way of endorsing infant and young child nutrition.

Article 3: **Definitions**

The definitions of the terms stated below are the definitions used throughout this Law.

1. **Advertise:** means to make any representation by any means whatsoever for the purpose of promoting the sale or use of a designated product including but not limited to:
   a. Audio, visual, or written publication including the books, television, radio, films, pictures, tapes (all sorts of videotapes, cassettes, disks, and compact disks), lectures, seminars, postal mail, e-mails, websites, telephones, mobile phones, SMS messaging, and faxes;
   b. Slogans, billboards, signs, pamphlets, brochures, booklets, posters, or any insinuation to or display of any product;
   c. Exhibition of pictures or models;
   d. Sponsoring an event or occasion through the product;
   e. Display or insert in any publication as a logo or sign of pregnancy or child birth in any publicity even if it is not in the scope of infants or young children feeding products like in the contraceptive means or gifts offered by traders including pictures or small models of designated products or on boxes or chocolate or flower arrangements or with and inside balloons designed for child birth occasions or even include these designated products in the gifts like feeding bottles or pacifiers in flower arrangements or balloons;
   f. Any other practice or means as the Minister of Health may, after consultation of the National Committee and by notice in the Official Gazette, declare to be a means of "Advertising" for purposes of this Law.
2. **Promote:** means to employ any method of directly or indirectly encouraging a person to purchase or use a designated product. This includes distributing samples of the products, free gifts, discounted gifts, or special offers for hospitals or physicians or others. Promotion includes what is called health assumptions.
3. **Market**: means to promote, distribute, merchandize, sell, or advertise a designated product, and includes product public relations and information services.
4. **Manufacturer:** means a natural or legal person, corporation, or other entity engaged in the business of manufacturing a designated product whether directly, through an agent, or through a person, or entity controlled by or under an agreement with it.
5. **Distributor:** means a natural or legal person, corporation, or other entity engaged in the business, whether wholesale or retail, of marketing any designated product.
6. **Minister:** means the Lebanese Minister of Health.
7. **Ministry:** means the Lebanese Ministry of Health.
8. **National Committee:** means the National Committee for the promotion and protection of breastfeeding, which monitors the implementation of this Law, and which is appointed in accordance with Article 18.

9. **Infant**: means a child from birth up to the age of one year (12 months).
10. **Young Child:** means a child from the age of one year up to the age of three years (36 months).
11. **Designated Product:** means
    a. Infant formula
    b. Follow-up formula
    c. Any other product marketed or otherwise represented as suitable for feeding infants and young children up to the age of three years
    d. Feeding bottles, teats, and pacifiers
    e. Such other product as the Minister of Health may, after consultation of the National Committee and by notice in the Official Gazette, declare to be a "designated product" for purposes of this Law.
12. **Infant Formula:** means a milk or milk-like product of animal or vegetable origin formulated industrially, and marketed or represented as intended to satisfy the nutritional requirements of infants from birth up to the age of one year.
13. **Follow-up formula:** means a milk or milk-like product of animal or vegetable origin formulated industrially, and marketed or represented as suitable for feeding infants and young children older than six months of age.
14. **Complementary food:** means any food suitable or represented as suitable as a substitute for or an addition to breastmilk, infant formula, or follow-up formula.
15. **Pacifier:** means an artificial teat for babies to suck. It is known by many names like "dummy".
16. **Container:** means any form of packaging of a designated product for sale as a normal retail unit, including wrappers and needles.
17. **Label:** means a tag, brand, mark, pictorial or other descriptive matter, written, printed, stenciled, marked, embossed, compacted, stuck or attached on a container of a designated product.
18. **Sample:** means a small or single quantity of a designated product even if of a large size, provided without cost.

19. **Health care facility:** means any establishment including public or private institutions, associations, organizations, public and private clinics, dispensaries, and medical centers engaged directly or indirectly in the provision of health care or in health care education such as medical faculties and universities. It also includes day-care centers, nurseries, infant and child care facilities, orphanages, shelters that house infants and children, clinics of private health workers, and any establishment for infant and child care.
20. **Health professional:** means a health worker with a professional degree, diploma or licence, such as medical practitioners, pharmacists, nurses, and midwives working in a health care facility, or such other person as may be specified by the Minister of Health after consultation of the National Committee and by a notice in the Official Journal, to be a "health professional or worker" for purposes of this Law.
21. **Health Worker:** means a person providing or in training to provide health care services in a health care facility whether professional or non-professional, including voluntary unpaid workers.
22. **Inspector:** means the pharmaceutical inspector appointed under Article 26.

Chapter II: Information and Education

Article 4

The Ministry is responsible for broadcasting or distributing the information and educational materials related to infant and young child feeding. It may delegate the task to the National Committee or any other party which has no direct or indirect commercial interest in infant and young child feeding in order to guarantee the implementation and compliance with the provisions of this Law.

Article 5

Information and educational materials, whether written, audio, or visual, which refer to infant and young child feeding shall:

1. Contain only correct and current information and shall not use any picture or text that encourage the use of a designated product, bottle-feeding, pacifiers, or discourage breastfeeding;
2. Be written in Arabic;
3. Not give an impression or create a belief that the designated product is equivalent to, comparable with, or superior to breastmilk or to breastfeeding;
4. Not contain the name, logo, drawing, trademark, or any other description of any designated product, nor of any manufacturer, marketer, or distributor provided that this clause (d) shall not be applicable to information about the designated product provided to health workers, as long as this information is restricted to scientific and factual matters regarding the nutritional content and methods of use of the designated product.
5. Clearly and conspicuously explain each of the following points:
   a. The benefits and superiority of breastfeeding
   b. The value of exclusive breastfeeding for six months, followed by sustained breastfeeding for two years or beyond
   c. How to initiate and maintain exclusive and sustained breastfeeding
   d. Why it is difficult to reverse a decision not to breastfeed
   e. The importance of introducing complementary foods from the age of six months
   f. How and why any introduction of bottle feeding or early introduction of complementary foods negatively affects breastfeeding
   g. That complementary food can easily be prepared at home using local ingredients.

Article 6

If the material referred to in article 5 includes feeding infants with infant formulas, follow-up formulas, or any other food or drink administered with feeding bottles or cups, it must include the

following points:

1. Instructions for the proper preparation and use of the product including cleaning and sterilization of feeding utensils;
2. How to feed infants and young children with a cup;
3. The health risks of bottle feeding and improper preparation and use of the product.

Article 7

Manufacturers and distributors of materials related to infant and young child feeding and nutrition must give the data to the National Committee in accordance with the published resolutions that serve the provisions of this Law.

Chapter III: Prohibitions related to Promotion

Article 8

A manufacturer, distributor, or marketer, shall not him or herself or by any other person on his or her behalf, promote any designated product in the points of sale, health care facilities, or any other place.

Prohibited promotional practices include but are not limited to:

Advertising;

1. Sale devices such as special displays, baby-talkers, discount coupons, premiums, rebates, special sales, loss-leaders, tie-in sales, prizes or gifts; provided that this clause -b- does not restrict establishing pricing policies and practices that aim at providing the designated products for long-term reduced prices.
2. Giving of one or more sample of a designated product to any legal or natural person, or any of the health care facilities, including hospitals and clinics;
3. Donation or distribution of any information or educational material referring to infant and young child feeding or performance of educational functions related to infant and young child feeding.

The persons mentioned in the above article may provide the information about designated products to health care professionals as long as it is restricted to scientific and factual matters, and related to technical concepts and methods of use of these products, and compliant with the articles of chapter 2 of this Law related to information and education.

Article 9

A manufacturer, distributor, marketer, any legal or natural person, shall not him or herself or by any other person on his or her behalf:

1. Donate or provide any quantity of the designated product to a health worker or a health care facility at lower than the published wholesale price where one exists, and in its absence, lower than 80% of the retail price;
2. Donate to or distribute within a health care facility equipment or services that carry, promote, or indicate the name, logo, drawing, trademark, or any other characteristic of a designated product, manufacturer, or distributor;
3. Donate to or distribute within a health care facility materials that include, among others, pens, calendars, posters, notepads, binders, growth charts, and toys which refer to or may promote, or indicate the name, logo, drawing, trademark, or any other characteristic of a designated product, manufacturer, or distributor;
4. Offer or give any gift, donation, or financial contribution to a health worker even if he is a trainee, or to associations of health workers engaged in mother and child health, to mother and child health care facilities, universities, medical faculties involved in pediatrics, obstetrics, gynecology, and nutrition, including but not limited to scholarships, research grants, or funding for meetings, seminars, continuing education courses or conferences;
5. Sponsor events, contests, telephone counseling lines, or campaigns addressed to pregnant women, nursing mothers, parents of infants or young children, family members and caretakers, nor sponsor campaigns related to reproductive health, pregnancy, childbirth, infant or young child feeding or related topics;
6. Include the volume of sales of designated products when calculating employee or worker remuneration or bonuses, nor set quotas for sales of designated products;
7. Perform educational functions related to pregnant women or mothers of infants and young children;
8. Contact pregnant women or mothers of infants and young children whether directly or indirectly in the framework of their work.

Chapter IV: Prohibitions related to the Container and the Label

Article 10

A manufacturer, distributor, or marketer shall not offer for sale or sell a designated product if its container or label affixed thereto includes pictures, drawings, or graphics other than those used to clarify the methods of preparation.

A manufacturer or distributor shall not offer for sale or sell a designated product unless the container or label affixed thereto indicates the following, in a clear, conspicuous and easily readable manner, in Arabic:

1. The words "Important Notice" in capital letters using a 14-sized font referring to the statement under it: "Breastmilk is the ideal food for infants and young children up to the age of two years. It promotes immunity and protects against diarrhea and other illnesses", in visible, darker, and larger characters than the other characters written on the container. The characters should be no less than one-third the size of the characters in the product name. The words "Important Notice" and the statement following it must be visible in the center of the container, even when held, and not be covered by anything including the container's lid and its extremities.
2. The word "Warning" and indicated thereunder, the statement:

a. For designated products other than the feeding bottles, teats, and pacifiers: "Seek the advice of a physician before using an infant formula. If you use a feeding bottle, your baby may refuse to feed from the breast. It is better to feed from a cup".
b. The warning word and the statement indicated thereunder should be written clearly, in darker, and larger characters using font (14). These characters should also be larger than those used for the product's name.

The warning word and the statement indicated thereunder should be clearly visible in the center of the container even when held, and not be covered by anything including the container's lid and its extremities.

3. The name and local address of the manufacturer or distributor printed on the container provided that the container is adequate and preserves the quality and safety of the product.
4. Any other detail possibly required.

Article 11

A manufacturer, distributor, or marketer shall not offer for sale or sell a designated product other than feeding bottles, teats, and pacifiers unless the container or label affixed thereto indicates in a clear, conspicuous and easily readable manner, in Arabic, the following particulars:

1. Instructions for appropriate preparation and use in words and in easily understood graphics;
2. The age after which the product is recommended in numeric figures;
3. A warning about the health risks of improper preparation and of introducing the product prior to the recommended age;
4. The ingredients used, and the source and kind of the milk or any comparable product;
5. The composition and nutritional analysis;
6. The required storage conditions both before and after opening the container, taking into account climatic conditions;
7. The batch number, date of manufacture, and date before which the product is to be consumed, and expiry date by day/month/year in a unencoded way, taking into account climatic and storage conditions;
8. The feeding chart with instructions of preparation stating the necessity of disposing the leftovers;
9. Does not use the terms "maternalised", " humanized" or terms similar thereto or any comparison with breastmilk;
10. Does not use texts that may tend to discourage breastfeeding;
11. In the case of follow-up formula, states that the product shall not be used in infants less than six months old.

Article 12

A manufacturer, distributor, or marketer shall not offer for sale or sell any feeding bottle or teat unless the container or label affixed thereto indicates in a clear, conspicuous and easily readable manner, in Arabic, the following particulars:

1. Instructions for cleaning and sterilization in words and graphics;
2. A statement explaining that feeding with a cup is better and more hygienic than bottle feeding;
3. A warning that children should not be left to self-feed for long periods of time because extended contact with sweetened liquids including infant formula, may cause tooth decay.

Article 13

A manufacturer, distributor, or marketer shall not offer for sale or sell the following:

1. Skimmed or condensed milk ina powder or liquid form unless the container or label affixed thereto contains the words: "This product should not be used to feed infants".
2. Low fat or standard milk in powder or liquid form unless the container or label affixed thereto contains the words: "This product should not be used as an infant's sole source of nourishment".

The statements in paragraphs -a- and -b- shall be written in characters darker, larger, font 14-sized and bigger than the other characters written on the container. The characters should be no less than one-third the size of the characters in the product name. They must be written in Arabic, in the center, clearly visible even

when held, and not be covered by anything including the container's lid and its extremities.
The products mentioned in the previous paragraphs -a- and -b- are not subject to the stipulations of this Law unless they are marketed or represented as being suitable for infant and young children.

Chapter V: Health Care Facility and Health Worker Responsibilities

Article 14

The Ministry, Minister, and heads of Health Care facilities shall take the adequate measures needed to protect breastfeeding and to promote this Law. They shall give information and advice to health workers regarding their responsibilities and particularly ensure that health workers are familiar with all the information specified in this Law.
Health care educational institutions shall incorporate "breastfeeding management" in their curricula.

Article 15

Health workers:
1. Shall encourage, support, and protect breastfeeding by encouraging pregnant women and mothers to breastfeed their children up to the age of two years or beyond;
2. Are expected to know the provisions of this Law, particularly chapter II related to information and education;
3. Shall work to promote practices that directly or indirectly lead to the initiation and continuation of breastfeeding.

Article 16

Health workers, health care facilities, and educational health and medical institutions related to mother and child health shall not:
1. Accept or receive any gift, contribution, benefit, money, or the like, no matter what the value may be, from the manufacturer or distributor of a designated product, or from their representative, or any other person;
2. Accept, receive, or give any sample of a designated product to anyone;
3. Clarify or explain the instructions of use of a designated product to anyone except individually to the mother or family members who need them. In this case, they shall give a clear and full explanation of the risks of improper or unnecessary use of the designated product with the information stipulated in chapter II of this Law related to information and education;
4. Conduct any kind of professional assessment, research, or activity related to a designated product in health care facilities without a pre-issued written approval from the National Committee.

Chapter VI: Administration

Article 17: **Implementation**

1. The Ministry is principally responsible for the implementation of this Law.
2. The Minister shall, when necessary, call upon other ministries to ensure the implementation of this Law.
3. For the purpose of implementing this Law, the Minister has the following powers and functions:
   a. To promulgate such rules as are necessary or proper for the implementation of this Law and the accomplishment of its purposes and objectives;
   b. To call for consultations with government agencies and other interested parties to ensure implementation and strict compliance with the provisions of the Act and the rules promulgated hereunder;
   c. To cause the enforcement of this Law;
   d. To exercise such other powers and functions that may be necessary for or incidental to the attainment of the purposes and objectives of this Law.

Article 18: **The National Committee for the promotion and Protection of Breastfeeding**

The Minister forms a National Committee for the promotion and protection of breastfeeding to implement this Law and the rules promulgated in accordance with its provisions.
The National Committee is composed of the following members:

1. The Director General of the Ministry of Public Health, president
2. The Director General of the Ministry of Economy and Trade, member
3. The Director of Preventive Medicine at the Ministry of Public Health, member
4. The President of the Order of Pharmacists of Lebanon or a representative appointed by the president, member
5. The President of the Order of Physicians of Lebanon or a representative appointed by the president, member
6. The President of the Order of Physicians of North Lebanon or a representative appointed by the president, member
7. The President of the Order of Nurses of Lebanon or a representative appointed by the president, member
8. A representative of the Midwives Association of Lebanon, member
9. A representative of the Higher Council of Childhood in Lebanon, member
10. A representative of the National Committee of Women Affairs in Lebanon, member
11. A representative of consumer protection organizations, member
12. A representative of organizations supporting and promoting breastfeeding, member
13. A legal consultant appointed by the Order of Lawyers, member
14. A representative of UNICEF, controller.
15. A representative of WHO, controller.
16. Provided that no person who has any direct or indirect financial interest in any designated product shall be appointed to the Committee.

Article 19

A Member of the National Committee assumes his/her tasks as long as he/she holds his/her administrative or governmental position. In case a member is not a government official, he assumes his/her tasks in the National Committee for three non renewable years, unless he/she no longer has his/her representative title.

Article 20: **Powers and Functions of the National Committee**

The National Committee has the following powers and functions:

1. To advise the Minister on national policy for the promotion and protection of breastfeeding;
2. To supervise the local committee in each Mohafaza;
3. To advise on designing a national strategy for developing communication and public education programmes for the promotion and protection of breastfeeding; information and educational materials on the topics of infant and young child feeding; continuing education for health workers and health care professionals on lactation management and the requirements of this Law;
4. To review reports and complaints of violations and other matters concerning this Law;
5. Such other powers and functions that the Minister entrusts the National Committee with.

Article 21: **The Local Committee**

A local committee is formed in each Mohafaza so as to assist the National Committee.
The local Committee is composed of:

1. The head of the Public Health Department in the Mohafaza from the Ministry of Public Health, president
2. An obstetrician-gynecologist, member
3. A pediatrician, member
4. A representative of organizations supporting and promoting breastfeeding member
5. A representative of consumer protection organizations, member

6. A pharmaceutical inspector, member and rapporteur

Provided that no person who has any direct or indirect financial interest in any designated product shall be appointed to the Committee.

The local committee is appointed by decision of the Minister of Public Health upon the suggestion of the Director General of the Ministry and consultation of the National Committee.

The members of the local committee shall hold office for a term of 3 years and shall be eligible for renomination as far as the nongovernmental members are concerned.

Article 22: **Powers and Functions of the Local Committee**

Local committees shall oversee the implementation of the National Committee recommendations. These committees have to submit a report to the National Committee pertaining to how the Mohafaza is implementing this Law and to problems encountered in monitoring and support.

Article 23

The National Committee holds a meeting, summoned by its chairperson, at least once a month, when necessary, or by the written demand of at least half its members.

1. The local committee holds a meeting, summoned by its chairperson, at least once a month, when necessary, or by the written demand of at least half its members, or when the National Committee requires so.
2. The National Committee or the local committees may invite national or foreign experts to take part in the meetings as observers.
3. Internal regulations specify the task of both the National Committee and the local committee by decision of the Minister of Public Heath upon the suggestion of the Director General of the Ministry.
4. Remunerations for attending the meetings of the National Committee and of local committees are decided by decree of the Council of Ministers upon the suggestion of the Minister of Public Health.

Chapter VII: Registration and Sale of Designated Products

Article 24

The following is applied for registry of designated products:

1. Designated products are registered at the Ministry of Public Health (Pharmacy Department) in accordance with the provisions of Pharmacy Practice Law. A special register is established for this purpose.
2. Upon adoption of this Law, a manufacturer, producer, vendor, or importer of a designated product shall straighten out his/her situation and register the product within six months of creating the register. After that period, he/she is prohibited from importing, manufacturing, selling, marketing, or displaying any unregistered or expired designated product.
3. No certificate of registration will be granted unless the designated product is in accordance with the quality standards recommended by the Codex Alimentarius Commission and in the Code of Practice of infant and child food products, and unless the container and the label affixed thereto are in accordance with the requirements stipulated in this Law.

Article 25

Designated products shall be sold only in pharmacies.

Chapter VIII: Pharmaceutical Inspectors

Article 26

Pharmaceutical inspectors at the Ministry of Public Health are responsible for monitoring the implementation of this Law.

Article 27

Any natural or legal person has the right to file a complaint to the Ministry or the National Committee related to violations of this Law and the rules made pursuant thereto. Upon receiving a report on violations of this Law and rules made pursuant thereto from an inspector or others, the National Committee submits its recommendations to the Minister in order to take proper legal actions.

Chapter IX: Penalties

Article 28

Any natural or legal person violating this Law and the rules made pursuant thereto is subject to the provisions of Chapter X of the Pharmacy Practice Law.
Health workers are subject, in addition to the aforementioned, to administrative sanctions that include temporary suspension of his / her work permit for a maximum duration of 6 months. In case of repeated violation, he /she will be forbidden from practicing his/her profession.
Health professionals are submitted to disciplinary sanctions according to the provisions and rules in use at the Order to which he/she belongs.

Chapter X: Final Provisions

Article 29

The resolutions required for the implementation of this Law shall be published in the Official Gazette especially:
1. Internal regulations and functions of both the National and Local Committees;
2. The conditions and procedures of registering designated products and creation of a special register at the Ministry of Public Health in order to monitor them;
3. The qualifications, powers and procedures entrusted to the inspectors appointed in accordance with this Law;
4. The procedures for submitting information and educational material to the National Committee;
5. Guidelines related to issuance of medical prescriptions for designated products.

Article 30

Details of the implementation of this Law shall be specified in decrees that will be taken at the council of ministers upon suggestion of the Minister of Public Health.

Article 31

The Legislative Decree No. 110 of 16 September 1983 related to Marketing of Breast Milk Substitutes is terminated with all the laws and regulations contradicting its provisions.

Article 32

This Law shall come into effect upon publication in the Official Gazette.

Appendix 11 Joint Statement on Optimal Infant and Young Child Feeding in Emergencies in Lebanon

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

REPUBLIC OF LEBANON
MINISTRY OF SOCIAL AFFAIRS

Optimal Infant and Young Child Feeding in Emergencies in Lebanon

A JOINT STATEMENT

November 2012

Issued by: MOPH, MOSA, UNICEF, WHO, UNHCR, WFP, UNFPA

Endorsed by:

IOCC

International Medical Corps

World Vision
رؤيتنا للبنان

AUB
American University of Beirut

Save the Children

This is a call for the support for appropriate infant and young child feeding in the current refugee situation in Lebanon, and caution about unnecessary and potentially harmful donations and use of breast-milk substitutes.

During emergencies, the risks for morbidity and mortality among under-five year old children are generally higher than other age groups, particularly due to their higher vulnerability to the combined impact of increased incidence of communicable diseases and diarrhea and increased rates of under-nutrition. The most effective and fundamental measure to prevent malnutrition and mortality among infants and young children is to ensure their optimal feeding and care.

Exclusive breastfeeding of infants during the first six months, with no introduction of other food or drinks including water, is the ideal natural nutrition, as it meets the nutritional requirements of the infant and provides valuable protection from disease and infection. After six months, introduction of adequate and safe complementary foods, **IN ADDITION** to breast milk, is necessary for the infant's increasing nutritional requirements.

RECOMMENDATIONS

1. Exclusive Breastfeeding for the first six months.

Rationale – *Protecting and supporting exclusive breastfeeding in normal situations and particularly in emergencies is important because:*

- Risks of infections are higher during emergencies. Breastfeeding provides a protective measure against the increased risks of illness among infants during emergencies.
- Stress, overcrowding and lack of privacy may temporarily disrupt breastfeeding or make it difficult to accomplish.
- **Providing infants with breast milk substitutes (BMS) in an emergency increases the risk of illness and mortality,** as hygiene and sanitation conditions as well as access to clean water are usually limited.

Note: Breastfeeding also provides major benefits for the mother, the first of which protection from breast, uterine, and ovarian cancer, type II diabetes, heart diseases, high blood pressure, and osteoporosis.

Action– *To protect breastfeeding practices:*

- **Encourage and support mothers to continue breastfeeding**.
- Provide "safe havens" for mothers to continue exclusive breastfeeding and/or re-lactation.
- Provide appropriate nutritious food and water for the lactating mother.
- Provide support for re-lactation when necessary.

- Find among population groups lactating women willing to breastfeed orphans or unaccompanied infants if culturally appropriate.

Conditions when replacement feeding is necessary:

- When a child is orphaned - and wet-nursing is not possible or culturally accepted.
- When a child is temporarily or permanently separated from mother.
- When the mother is unable to breastfeed for accepted medical reasons (according to WHO and UNICEF standards).
- When mothers have stopped breastfeeding and re-lactation efforts have failed under the supervision of a trained health worker.

Guidelines to follow for replacement feeding in emergencies – according to the International Code of Marketing of Breast-milk Substitutes (BMS) and the World Health Assembly resolutions:

- **A general distribution should NEVER include breast-milk substitutes or any other milk products.** BMS should only be provided to infants with exceptional conditions who cannot or should not breastfeed (as per WHO and UNICEF standards which are adopted by the National Program for IYCF). Individual case assessments should be conducted by personnel who have received training in infant and young child feeding in consultation with health and nutrition personnel.
- **Organizations must NEVER accept unsolicited donations of ANY milk products.**
- The milk product should conform to the Codex Alimentarius standards for labeling in the appropriate language according to the International Code of Marketing of Breast-milk Substitutes and Lebanese law 47/2008.
- In exceptional cases when use of infant formula is indicated, the infants' caregiver(s) should receive training on how to properly handle the formula. Caregivers should be encouraged and taught to feed with a cup and spoon.
- **Infant formula should only be sourced and distributed when there is access to adequate clean water, when resources are available to continuously provide infant formula and to prepare formula safely, with family support and access to health services.**
- The use of infant feeding bottles and artificial teats in emergency settings should be actively **discouraged**.

2. Complementary Feeding

Rationale – ***After six months of age***, *infants' requirements increase beyond what is provided by breast milk alone, and therefore* **infants should receive complementary foods IN ADDITION to breast milk.**

- The complementary foods should be age-appropriate, nutritionally adequate, safely prepared and continuously provided.

- Agencies should encourage use of local products and avoid commercially marketed products.

3. Key References:

- International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions. WHO (1981).
  Available at: www.unicef.org/nutrition/files/nutrition_code_english.pdf

- Operational Guidance on Infant and Young Child Feeding in Emergencies,v2.1,Feb2007
  Available at: www.ennonline.net

- UNHCR Policy Related to the Acceptance, Distribution and Use of Milk Products in Refugee Settings, revised edition, UNHCR (2006).
  Available at: www.ibfan.org

- Module 2 on Infant Feeding in Emergencies, v1.1, Dec 2007, for health and nutrition workers in emergency situations.
  Available at: www.ennonline.net/ife

4. For more information please contact:

- Ministry of Public Health, Infant and Young Child Nutrition Program, Beirut: iycfprogramleb@gmail.com

Appendix 12 Strategic Documents and Policies Published by the Government of Lebanon or UN Agencies and NGOs

Issue Date	Type of document	Published by	Name of document	IYCF provisions
1981	Decree	Government of Lebanon	Not available	• Based on the WHO Code of Marketing of Breas-tmilk Substitutes (El Zein, 2012).
1993	Public announcement #65	Ministry of Public Health	Not available	• Prohibits the distribution of the samples of breast-milk substitutes and the hanging of posters or pictures or ads by formula companies in any governmental institution (El Zein, 2012).
1993	Public announcement #66	Ministry of Public Health	Not available	• Committing governmental hospitals and governmental institutions to the ten steps of baby friendly hospitals (El Zein, 2012).
2006	Joint statement	MoPH, MOSA, UN agencies, INGOs	Joint statement on infant and young child feeding during emergencies	• Based on the model joint statement for IYCF-E (ennonline.org, 2014b).
2007	Strategy	Ministry of Public Health	The MOH Strategic Plan	• Includes an activity on reactivation of the baby friendly hospital initiative on page 11. • Includes a key performance indicator on # of breast-fed newborns within first 12 hours in Baby Friendly hospitals.

Issue Date	Type of document	Published by	Name of document	IYCF provisions
2008	**Law**	**Government of Lebanon**	**Organizing the Marketing of Infant and Young Child Feeding Products and Tools**	**Yes (Based on the Code of Marketing of Breastmilk Substitutes)**
2012	**Joint statement**	MoPH, MOSA, UN agencies, INGOs	**Joint statement on IYCF in emergencies during the Syria refugee crisis**	**Yes (Based on the model joint statement for IYCF-E)** (ennonline.org, 2014b)
2015	Plan	Ministry of Public Health	Emergency Health Contingency Plan	• No mention of breastfeeding, infant feeding, or complementary feeding. • Lactating women are mentioned as part of a section highlighting the need for coordination with UNFPA to support reproductive health needs. • Document focuses on acute health needs including communicable diseases. • Annexes include IMCI so it includes IYCF guidance but not specific to emergencies and not sure if it is specific to Lebanon.
2015	Response plan	Government of Lebanon and UN agencies	Lebanon Crisis Response Plan 2015-16	• No mention of breastfeeding or complementary feeding. • Primary health and reproductive health are mentioned once under priorities.
2016	Strategy	Ministry of Public Health	Health Response Strategy. Maintaining Health security, Preserving Population Health & Saving Children and Women Lives – A new approach 2016 and beyond – October 2016	• No mention of breastfeeding or complementary feeding. • Nutrition is mentioned within primary health care on page 15 and as part of the role of the municipalities on page 25.

Issue Date	Type of document	Published by	Name of document	IYCF provisions

2017*	Response plan	Government of Lebanon and UN agencies	Lebanon Crisis Response Plan 2017 - 2020	• Breastfeeding is mentioned three times
				  ○ On page 13 and pages 90 documenting the rate of breastfeeding amongst Syrian refugees (34%)
				  ○ On pages 98 referring to breastfeeding awareness at the primary health level
				• The document mentions that Lebanon does not have an IYCF strategy to guide activities
				• Infant and young child feeding is mentioned in the health sector.